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IMJ

Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY



***LATEST
ADVANCES IN
DERMATOLOGY***

SEE PAGE 46

“Die grossen Anfälle schienen in ihrer Schwere gebrochen, verliefen ohne erbrechen...”*

Ménière's syndrome: The Viennese have a word for it

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*Pichler, H.: HNO 4:178-179 (May 28) 1954.

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Illinois Medical Journal

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July, 1965

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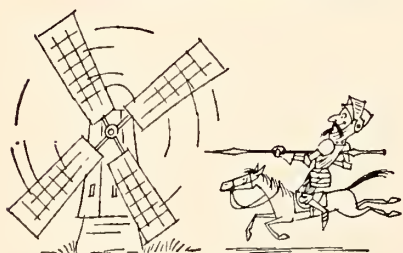
Don Quixote's valor fell victim to vertigo.



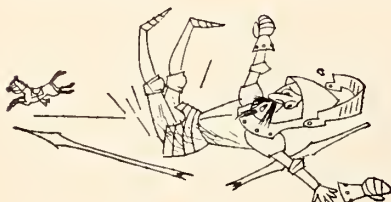
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References: 1. Scal, J. C.: Eye Ear Nose & Throat Month. 38:738 (Sept.) 1959. 2. Based on 1964 data from independent physicians' market survey organization.



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Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

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Burtis E. Montgomery, M.D.

— president's page —

STILL THE BEST INVESTMENT

ON PAGE 57 OF THIS ISSUE begins a published report that is unique in the annals of state society communications with its membership. It is unique not only because it relates the financial structure of ISMS in minute detail, but because it traces in a very real and tangible way the progress and growth of our society in the past half decade.

As Chairman of the Council which helped to institute sweeping changes in ISMS programming and policy in 1960, and later as Finance Committee Chairman, I have had the good fortune to witness the effects of these changes from close by. In the short span of five years, I have seen the Illinois State Medical Society truly "come of age" with a totally new and expansive program designed to serve more efficiently our patients, ourselves, and the medical community in which we live.

Before these changes were instituted, we sorely needed closer and more effective communications with the public. We got it. We needed more active and powerful committees to cope with the myriad changes brought on by the latest scientific advances. We got that, too. We needed stronger and

closer participation in affairs of mutual interest with the voluntary health agencies, approved paramedical groups, and other professional agencies. This we also got.

Finally, we needed stronger legislative representation that would better define our policies in public affairs and work to assure that laws reflected the best interests of our patients and the hallowed system of free medicine for which we all stand. Most emphatically, we got that also.

To make certain that these achievements keep on growing to meet the new and ever-increasing demands placed upon our profession, it was necessary to assign an increase in dues structure this year. The unprecedented report published in this issue tells in detail WHY this increase is needed; WHERE it will be spent; and HOW it will work to benefit the profession of medicine throughout our state.

Upon reading this report, I am certain you will agree that the added dues dollars you relinquish this year will be used in significant programming vital to all of us—programming which continues to make your dues one of the most solid and lasting investments yet conceived.

NEW DEVELOPMENTS IN THE TREATMENT OF CORNEAL DISEASE

Charles I Thomas, M.D./cleveland, ohio

WE ARE LIVING AT A TIME when professional and general scientific advancement is so tremendous that it is almost impossible for each of us to keep abreast of new developments in our own separate disciplines. Productive research involving many scientists is coming from many institutions and the findings of these multiple programs in the basic sciences and in clinical investigation are changing our concepts of disease and consequently our methods of medical and surgical treatment. In many ways, our generation must be freed from many of the scientific ideas that bind us to the thinking and methods of our predecessors. Only in this way can we progress. But in exploring new pathways, the motivation for investigation into unknown fields must be based upon a sound knowledge of past accomplishments.

Professor of Ophthalmology, Western Reserve University and Director of Ophthalmology, University Hospitals, Cleveland, Ohio.

From the wealth of recent developments in ophthalmology and related sciences I have chosen only two of the newer methods of treatment of the cornea, one medical and the other surgical. These concern (1) the anaphylactic component in herpes simplex infection and (2) keratoprosthesis.

HERPES SIMPLEX KERATITIS

At present, in therapy of herpes keratitis we have been provided with a powerful therapeutic agent in 5-iodo-2-deoxyuridine, more commonly known as IDU.¹ With this substance virus multiplication can be suppressed as never before. Nevertheless, it has also become evident that when interstitial tissue is involved in this disease, factors other than specific cellular herpes virus infection must be dealt with. The anaphylactic component, which was emphasized years ago, is assuming new importance in etiology and thanks again to a therapeutic triumph in the development of the corticosteroids, the entire problem presented by herpes keratitis can be managed much more effectively.

Our conclusions are based on a series of 75 cases of interstitial herpes which we have studied over the past two years. The patients received IDU alone and in combination with topical and, at times, systemic steroids. Because of the apparent effectiveness of IDU and the seriousness of this disease, untreated cases were not included,

as in the so-called double-blind type of clinical study. Instead, the results of IDU therapy were compared with those obtained in cases treated by various measures before the advent of IDU. Pertinent literature on herpetic keratitis published during the past twenty years reveals how generally unsatisfactory were these other therapeutic methods and how frequently it was necessary to perform a keratoplasty in these cases.

It became evident early in our investigation that, although IDU exerted a favorable influence on epithelial or dendritic keratitis, its effect was rather disappointing when the stroma of the cornea was involved, either alone or with dendritic ulceration. In these cases with interstitial involvement, topical steroids were used in combination with IDU because it was believed that there is an important allergic component in this form of the disease, especially in the disciform type. It was postulated that if viral multiplication could be inhibited with IDU, the anti-inflammatory effect of the steroids could then safely exert a favorable influence on the anaphylactic component affecting the deeper corneal tissues.

Materials and Methods

The therapeutic agent used was a 0.1 percent aqueous solution of 5-iodo-2-deoxyuridine. Patients were instructed to instill two drops into the conjunctival sac every two to three hours during the day and, whenever possible, every three to four hours at night. This routine was followed in the first twenty-five cases, but in the last fifty cases in our series, the medication was instilled less frequently, sometimes only three to four times a day. With the advent of the IDU ointment, which is now available for investigative use, less frequent applications, sometimes only two or three a day, were necessary. A broad spectrum antibiotic was combined with the cortisone acetate or cortisol solutions which the patients were instructed to instill at the same time as the IDU. The duration of treatment varied from one to six months in most cases.

No virologic studies were performed and the cases were all diagnosed on the usual

morphologic basis. All patients so diagnosed throughout the period of the study were included. All were examined by one observer. The criteria for improvement can be seen in Table 1. All these criteria had to be met before the case was classified as improved.

Superficial Dendritic and Geographic Ulceration Combined with Diffuse Stromal Involvement.—In our series there were forty cases of diffuse stromal keratitis with superficial ulceration. Treatment with IDU alone proved to be mostly ineffective (Table 2), but when this was combined with topical steroids, immediate or short-term improvement was obtained (Table 3). The so-called metaherpetic lesion of the cornea seen most often in association with the diffuse interstitial type of involvement does not require IDU or topical corticosteroids to bring about healing. This condition, a form of recurrent corneal erosion, will heal by protection either with an emollient or tarsorrhaphy. This strongly suggests a neurotrophic change in the epithelium, which is, of course, characteristic of this disease.

All cases in this group were of several months' duration and had been characterized by frequent relapses before IDU therapy was started. Most of these cases showed typical recurrent ulcerations of varying size and number located over a diffuse branching type of stromal lesion. Early in the study, IDU alone was used in five cases for periods of two to three weeks; one showed improvement and four remained unchanged (Table 2). Three of these four ultimately resolved with combined therapy and one required lamellar keratoplasty. In the remaining cases plus the three from the group originally treated only with IDU, improvement was prompt after combining the IDU with topical corticosteroids. The improvement consisted in regeneration of normal epithelium and a decrease in stromal infiltration and edema, and replacement of the original lesion by scar tissue.

The effectiveness of the combined therapy is well illustrated by the case of a 10-year-old girl who had previously received ster-

oids systemically for rheumatoid arthritis. A dendritic ulcer was present in the corneal epithelium and a deep stromal infiltrate existed when she was first examined in our clinic. The lesion appeared to extend to the endothelial surface, which showed a dendritic pattern in the immediate vicinity of the stromal disease. IDU administered for six days resulted in no improvement. When topical steroids were added, the lesions showed marked change within several days. The supply of IDU was then temporarily exhausted and the epithelial lesion recurred, along with reactivation of the stromal disease. IDU and topical corticosteroids were resumed after a few days and, within two weeks, the lesion again improved and has remained quiescent for one year.

In the group with interstitial herpetic keratitis, four of thirty-nine patients did not respond after repeated treatment with IDU and topical steroids (Table 3). The usual course of combined therapy was followed for two months. Of these four patients, three were later treated by lamellar keratoplasty with good results and one responded satisfactorily to neurotropic toxoid, which is also under experimental investigation at present.

Disciform Keratitis.—Thirty-five cases of disciform keratitis were included in this study. In the first two patients observed in this group, IDU alone was prescribed every two hours for three to four days. One patient improved and one failed to respond. The latter then received combined treatment which yielded excellent results.

To illustrate a case with a long history, one patient presented an extremely severe

TABLE 1

CRITERIA FOR EVALUATION RESPONSE TO COMBINED IDU-CORTICOSTEROID THERAPY

Type of Disease	Criteria for Improvement*
Epithelial herpetic keratitis	<ol style="list-style-type: none"> 1. Decrease in pain, photophobia and lacrimation 2. Regeneration of normal epithelium 3. Failure to stain with fluorescein
Interstitial stromal keratitis with ulceration	<ol style="list-style-type: none"> 1. Decrease in pain, photophobia and lacrimation. 2. Healing of the superficial ulceration 3. Decrease in stromal edema and infiltration 4. Subsidence of iritis 5. Biomicroscopic evidence of disappearance of all stromal edema as sign of complete control
Disciform keratitis	<ol style="list-style-type: none"> 1. Decrease in pain and photophobia 2. Clearing of stromal lesion 3. Subsidence of iritis 4. Biomicroscopic evidence of disappearance of all stromal edema as sign of complete control

*All criteria had to be met for classification as satisfactorily improved.

disciform keratitis recurrent over a period of six months, with marked iritis that had been totally resistant to all previous therapy. Five days after beginning treatment with IDU alone, the eye had become more uncomfortable and irritable and the condition generally was thought to be worse. Twenty-four hours after combined therapy was inaugurated, steady improvement was evident, with subsidence of the iritis and associated pain, along with clearing of the cornea. Continuation of treatment for two months resulted in complete clearing of the

TABLE 2

RESULTS OF TREATMENT OF HERPETIC KERATITIS WITH 5-IDO-2-DEOXYURIDINE ALONE

Type	Cases	Improved	Unchanged	Recurrence	Controlled Recurrence
Dendritic plus diffuse interstitial keratitis	5	1	4		
Disciform keratitis	2	1	1		

TABLE 3

RESULTS OF TREATMENT OF HERPETIC KERATITIS WITH 5-iodo-2-DEOXYURIDINE
PLUS STEROIDS

Type	Cases	Improved	Unchanged	Recurrence	Controlled Recurrence
Diffuse interstitial keratitis	39	35	4	5	5
Disciform keratitis	34	30	4	8	8

iritis and the eye became white and asymptomatic. The corneal infiltrate decreased so that only a diffuse fine stromal haze remained; vision improved to 20/25. The patient remained symptom-free for two more months and then experienced a mild relapse, associated with iritis and a diffuse fine corneal edema. IDU and topical steroids were resumed and in three days the eye appeared quiet and has remained so for a period of eighteen months.

In this group of patients with disciform keratitis, four failed to respond to combined treatment with IDU and corticosteroids. Three of these four patients had presented with typical dendritic keratitis which cleared satisfactorily after iodine cauterization. Within twelve to fourteen days, each had developed a typical disciform stromal lesion in the area of previous dendritic ulceration. Incidentally, it is interesting to note that we did not observe this complication after any of the cases in which IDU alone was used as primary treatment of epithelial keratitis. Two of these four patients who failed to respond to combined medical therapy were treated by lamellar keratoplasty with good results. The other two showed a purulent breakdown in the disciform area and required diathermy to resolve the infection.

Recurrences.—A complete discussion of recurrences is beyond the scope of this presentation, but a few general statements can be made on the basis of our findings. The chronicity of the disease did not alter the initial response to treatment and there did not appear to be any relationship between the duration of the disease before treatment was started and the number of recurrences, provided treatment was continued as long as there was biomicroscopic evidence of

stromal keratitis. The presence of edema as determined by slit-lamp microscopic examination of the cornea was the clinical finding that determined the presence or absence of active inflammation. Recurrences could always be expected when combined treatment was stopped before the edema had completely disappeared. Our evidence indicates that some recurrences will take place but there does not appear to be any difficulty in keeping the inflammatory reaction in a quiet state, even though treatment in some cases has been continued for over a year.

Discussion.—The theory that anaphylaxis plays a role in stromal herpes gains strong support from an analysis of the chronology of this disease. It is also supported by the failure, except in very rare instances, to find virus in the disciform lesion. The two-week interval between onset of the superficial herpes keratitis and the appearance of the disciform lesion certainly is of the order of time that would be necessary to induce a state of hypersensitivity. A stromal lesion is likely to follow a recurrent episode of epithelial keratitis more quickly, that is, within two to three days, than does the initial interstitial corneal herpes. This suggests a sensitization of this tissue by previous infection. This is in accord with Breebaart's² observations of corneal hypersensitivity to horse serum. There are also striking morphologic similarities between the appearance of the disciform lesion of herpetic keratitis and the lesion associated with hypersensitivity reactions to horse serum. Although disciform keratitis is a typical form of corneal anaphylactic reaction, we believe the same mechanism is involved in producing the diffuse type of in-

terstitial keratitis, despite the morphologic differences. Successful therapy with corticosteroids can be presented as additional evidence of the allergic character of deep corneal herpes.

The work of others supports this view, Jones³ noted marked improvement in cases of parenchymatous herpetic keratitis treated with topical corticosteroids, but warned that such a lesion must be carefully treated to avoid recurrence or extension of the epithelial infection. He thought that the stromal disease was a pure immunologic reaction and on this basis felt that corticosteroids could be effective.

Braley⁴ believed disciform herpes represented a lesion of hypersensitivity with the herpes lesion acting as an antigen combined with the local circulating antibodies to initiate the hypersensitivity reaction. He also indicated that cortisone was effective in this disease because it blocked local hypersensitivity reactions.

This evidence, along with our observations, strongly supports the opinion that there is an allergic component in the stromal phase of herpes keratitis. To establish this definitely would greatly enhance our understanding of this disease. It would be unjustifiable to assume that the morphologic similarity between parenchymatous herpes and corneal hypersensitivity reactions is proof of similar pathogenesis, but at any rate this similarity provides evidence in favor of this hypothesis.

KERATOPROSTHESIS

In the history of keratoplasty, it is interesting to note that the first operation performed on the cornea⁵ consisted of the removal of a scarred cornea and its replacement by a watch crystal. Present research is directed toward a return to this idea with use of an inert substance. As with any prosthetic material employed in surgery, we are always attempting to select substances that can be well tolerated over a long period of time. It appears that silicon, in the light of our present knowledge, fulfills these requirements. Other substances have also been tried. About ten years ago, we conducted a study of corneal prosthesis, using

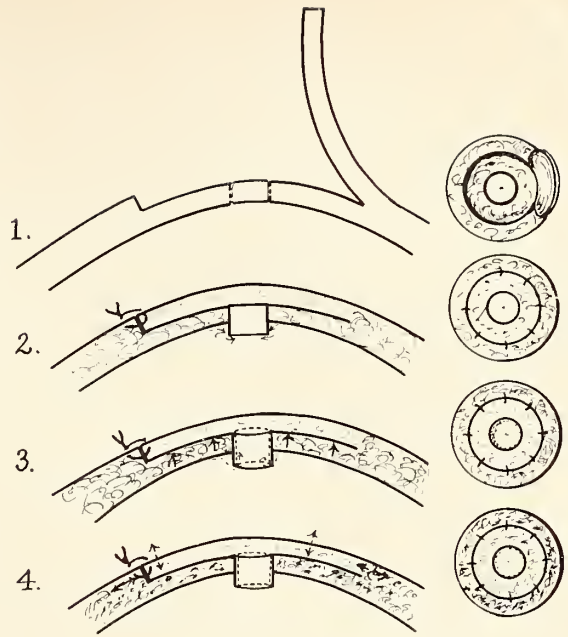


Fig. 1. Silicon cylinder and disk used in keratoprosthesis.

mylar disks. Over a period of a year, such material was gradually absorbed from the interlamellar space, although there was no accompanying inflammatory reaction.

Why is keratoprosthesis necessary? By no means is every case of corneal clouding suitable for transplantation procedures. Many of the dystrophies, the heavily scarred vascularized corneas, and those with persistent opacification of grafts, probably comprise the largest group of cases wherein keratoprosthesis can be of value. Although our present refinements in surgical technic have enabled us to perform the grafting operation successfully in previously unfavorable cases of endothelial dystrophy, the underlying problem of unhealthy endothelium is a detriment to a successful result.

Several types of prosthetic disks, all of which are fundamentally similar, are being investigated at present. The disk that we have been using is a cylinder measuring 2 to 3 millimeters attached to a disk of 5 to 6 millimeters (Fig. 1) which is inserted into the interlamellar substance of the cornea. We have been experimenting with a slight variation in the prosthesis which has several advantages over those previously used. The center pillar or cylinder has been re-

placed by a silicon tubing with an outside diameter of 2 millimeters and the interlamellar disk is a thin silicon sheet which is soft and flexible, so that it follows accurately the corneal curvature. The advantage of the hollow cylinder is that any growth over the edge of this structure must travel in, up and around the tube before it can obstruct, whereas with a solid cylinder it can do so by proliferating merely 2 to 3 millimeters.

Technic.—The operative procedure for the insertion of such a prosthesis is in itself quite simple. A lamellar graft is performed in the routine manner, allowing a little more dissection than the diameter of the disk to be inserted, and leaving an area to remain intact to the surrounding cornea. After preparation of this bed, a 2-millimeter trephine cuts through the center of the inner portion of the cornea, entering the anterior chamber. Into this dissected and penetrated area of the cornea is inserted the prosthesis which seals the trephine wound and rests upon the lamellar structure. The superficial corneal layer is put back in place and sutured securely.

Pathologic Physiology.—The alterations in the normal physiology of the cornea and the adjustments to these processes determine whether or not the procedure will be successful. The important factors to be considered are: (1) wound healing, (2) irritation due to foreign body and (3) corneal turgescence and dehydration.

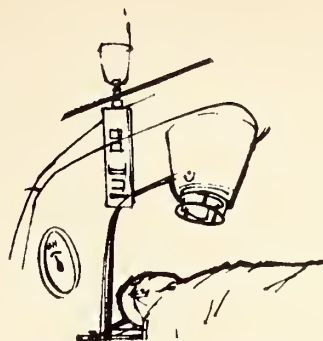
Wound healing usually progresses at a normal rate. There is no problem with the lamellar portion of the dissected area. The inner or endothelial portion at the junction of the cylinder at times presents a problem because of proliferation of fibrous tissue which may cover over the inner or anterior chamber portion of the prosthesis. This may interfere with proper function of the cylinder as a clear avenue for vision. Our hollow tube has been designed with the hope of minimizing this problem. Irritation or inflammatory reaction due to the foreign body or to substances liberated chemically, which naturally depends on the degree of inertness of the prosthesis, could result in failure of the procedure. The cases in which silicon prostheses have been inserted have not been under observation long enough to evaluate this factor definitely.

Corneal turgescence and dehydration appear to be strikingly affected by keratoprosthesis. In a case of endothelial dystrophy, that portion of the cornea in front of the silicon disk resumes normal deturgescence and hydration, while that behind the disk in direct continuity with the porous endothelium continues to be edematous and opaque. Sufficient exchange of metabolic products both by diffusion from the periphery and gaseous exchange by way of the epithelium and atmosphere allow this tissue to remain in a state of balance that results in normal transparency.

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Medical Progress



HARVEY KRAVITZ M.D./progress editor

CLINICAL SIGNIFICANCE OF SPECIFIC FINDINGS IN ELECTROENCEPHALOGRAPHY

PARTS 3 AND 4 OF
A 4 PART SERIES

F. A. Gibbs, M.D., and E. L. Gibbs/chicago

PART 3

PAROXYSMAL DYSRHYTHMIA

Diffuse Paroxysmal Slow

Diffuse 3 to 7 per second waves of moderately high amplitude occurring in bursts (lasting 1 to 3 seconds) in awake and drowsy recordings (Fig. 5) indicate a slight depressive and irritative reaction to some type of mild injury. Such bursts are usually bilateral. As an exclusive abnormality, paroxysmal slow activity occurs chiefly among adults, and it is usually maximal in the frontal and parietal areas. Among children it is commonly maximal in the occipital areas, and must be carefully distinguished from the slow waves of drowsiness which are normal in children below 8 years of age. Diffuse paroxysmal slow activity is rarely an exclusive abnormality in childhood. If epilepsy or a question of epilepsy is present and paroxysmal slow activity is present in the waking electroencephalogram, sleep usually reveals spike discharges. Diffuse paroxysmal slowing, when it appears alone, is not diagnostic of epilepsy but it is commonly associated with epileptiform symptoms.

Runs of Slow Activity

Bilateral runs of slow waves in the

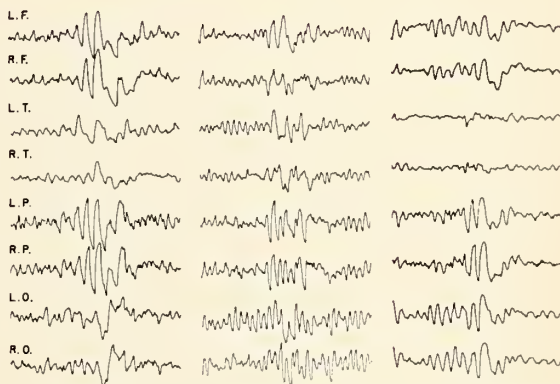


Fig. 5—Three examples of paroxysmal slow activity.

awake recording and during drowsiness, lasting 3 to 10 seconds (Fig. 6), are usually maximal in the frontal and parietal areas, and in this location they have a frequency in the 5 to 7 cycles per second range. In rare cases, when they are maximal in the occipital areas, their frequency is 4 to 5 cycles per second; and in such cases visual defects are common. However, they are mainly an adult pattern. Runs of slow activity are a more epileptic pattern than diffuse paroxysmal slow activity, the incidence of seizures among persons with runs of slow activity is double that of a matching group with normal electroenceph-

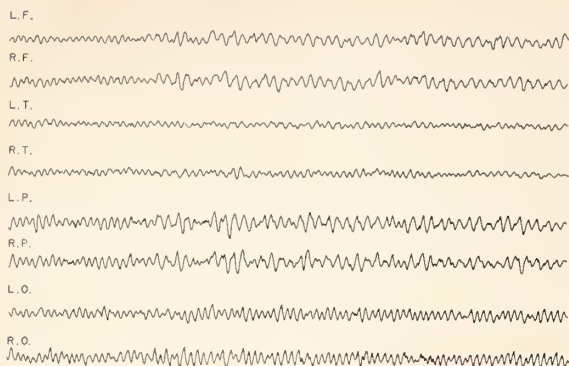


Fig. 6—Runs of slow activity.

alograms. This pattern is commonly associated with neurological deficits. The incidence of mental retardation is about double that of the matching group with normal electroencephalograms. Psychiatric disorder and behavior disturbances do not correlate with this pattern. The etiology is nonspecific.

Mitten Patterns

The mitten pattern¹⁶⁻²⁰ is an abnormal sleep pattern; it is rarely seen in normal control subjects. As a rule it is bilaterally synchronous and usually most evident in the frontal and, to a less extent, in the parietal (central) areas (Fig. 7). A fast and a slow component alternate to form a pattern resembling a slow spike-and-wave, but the fast component has a duration of only $\frac{1}{6}$ to $\frac{1}{12}$ second, and does not appear spiky but rounded, so that the formation looks something like the outline of the thumb and hand portion of a mitten. The "thumb" of the mitten is usually formed by the last wave of a slow frontal spindle (6 to 12 per second spindle).

The term *A-mitten* is applied to a mitten pattern in which the fast component (the "thumb") has a duration of $\frac{1}{8}$ to $\frac{1}{9}$ second, in contrast to the B-type which has a duration of $\frac{1}{10}$ to $\frac{1}{12}$ second. Thus, the A-mitten is a slow mitten and the B is a fast mitten (somewhat transitional toward a spike-and-wave pattern). A mitten pattern with a thumb duration of $\frac{1}{8}$ to $\frac{1}{7}$ second, i.e., one that is slower than an A-mitten, has been termed an A-1 mitten. There is a wide overlap between these types of mittens; one-third of the cases are mixed types and cannot be classified as belonging to any single type. The A-1

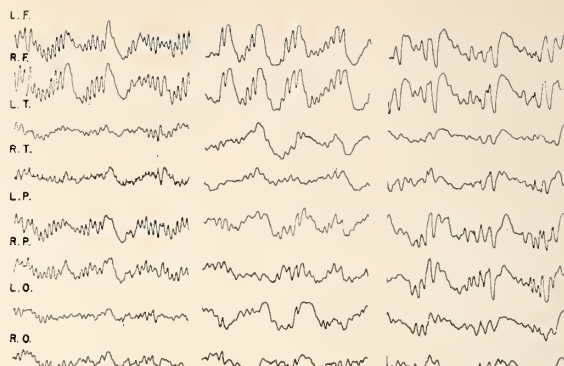


Fig. 7—Three types of mitten patterns. First strip B type; most commonly seen in psychosis. Second strip shows a slower mitten pattern, the A type; it is most commonly seen in parkinsonism. Third strip a very slow A-1 type of mitten pattern; it is most commonly seen in cases of deep tumor and of cerebral vascular accidents involving the central gray masses.

mitten is often seen in adults with deep tumors (particularly thalamic) and in patients with cerebral vascular accidents or degenerative diseases involving deep structures. The A-mitten is most often associated with parkinsonism, and the B-mitten with psychosis. Mittens are almost exclusively an adult abnormality. They are not epileptic, but the B-type correlates more with epilepsy than the other types and it is particularly common in epilepsy with psychosis. All types of mittens correlate with psychosis, psychiatric symptomatology, disturbances of behavior, psychopathy, intellectual defects and tremor. They are nonspecific as regards etiology.

Triphasic Slow Waves

A special wave form referred to as *triphasic slow waves* (Fig. 8) is commonly seen in patients with hyperammonemia.²¹⁻²³ They are an ominous sign for they are usually associated with severe hepatic insufficiency and impending coma.

The pattern resembles a very slow spike and wave or a slow mitten; it is most evident in the frontal areas and is not a sleep pattern. The first negative component usually starts from high on the side of a preceding negative deflection, not as with the spike and wave or mitten patterns from the bottom of a positive trough. Triphasic waves commonly appear singly with a du-

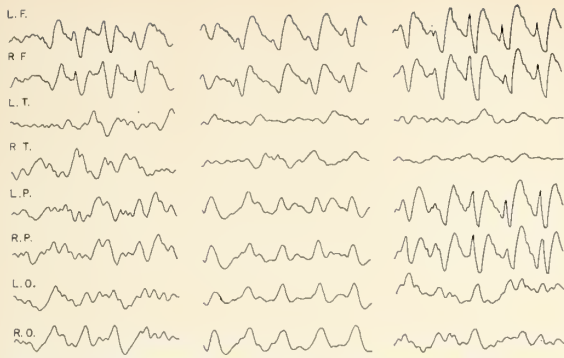


Fig. 8—Triphasic slow waves, common in severe hepatic insufficiency.

ration of 1.5 seconds, or in short runs.

PART 4

Hypsarhythmia

A random mixture of very high voltage slow waves and high voltage spike discharges, referred to as hypsarhythmia (Fig. 9), is a type of abnormality that is almost exclusively confined to infants and young children. It is an epileptic pattern being almost invariably associated with a history of frequent spasms, or brief quivering spells. Convulsions may occur, but they are not usually an outstanding feature of the symptomatology. Severe neurological deficits and intellectual defects commonly develop if the disorder continues. These are the outstanding symptoms in 80 percent of cases. The electroencephalogram may return to normal, but usually it changes to multiple foci of seizure activity. In the majority of cases the child's intellectual development remains permanently impaired.

Hypsarhythmia can be caused by trauma

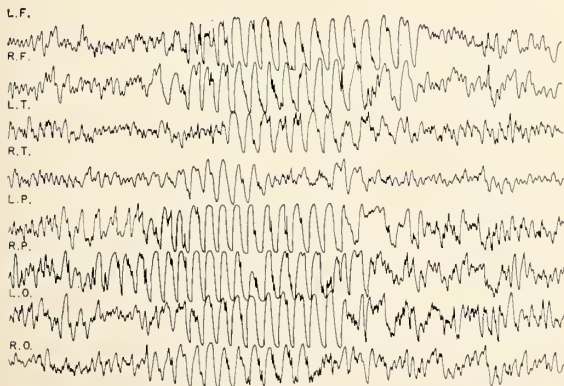


Fig. 10—Pseudo petit mal.

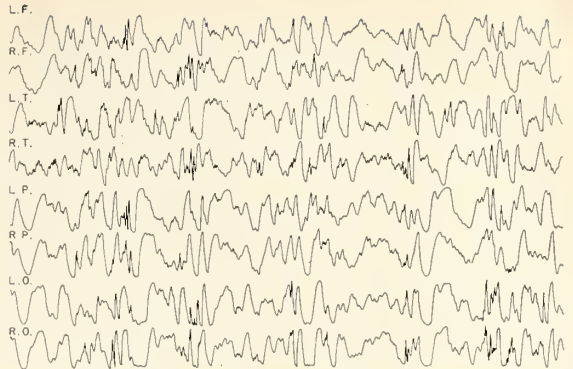


Fig. 9—High voltage irregular slow activity with spike seizure discharges appearing independently in all areas. Hypsarhythmia.

or anoxia at birth, by encephalitis or by metabolic defects, notably phenylketonuria²⁴⁻²⁵ and hypocalcemia. It can be associated with various developmental defects. No cases have been reported where hypsarhythmia was produced by a tumor. When a cause can be found and when treatment can be directed toward reducing or eliminating the cause, this is, of course, the proper therapy, but one-third of cases with hypsarhythmia, regardless of cause, improve greatly when treated with maximal tolerated doses of ACTH.²⁶⁻²⁹ Resistant cases usually respond well to RO5-3059 (Roche), a Librium Analog.³⁰

Pseudo Petit Mal Discharge

Paroxysmal diffuse 3 to 4 per second slow waves, with a poorly developed spike in the positive trough between the slow waves, occurring only in drowsiness and usually most prominent in the parietal areas, are classified as pseudo petit mal (Fig. 10). This is a mild abnormality of



Fig. 11—Petit mal variant.

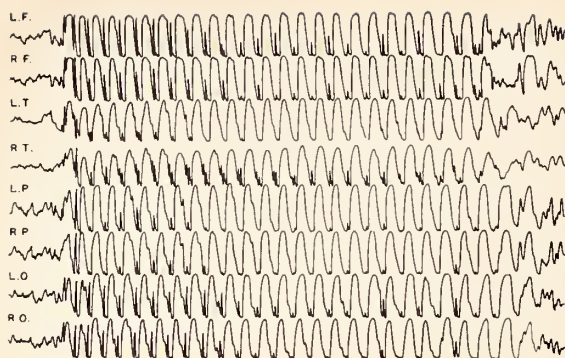


Fig. 12—Petit mal.

infancy and early childhood. It is the only pattern that is significantly associated with febrile convulsions.³ We have called it pseudo petit mal because it resembles the classical 3 per second spike-and-wave of petit mal, but it does not correlate with brief lapses of consciousness such as occur in association with the 3 per second spike-and-wave of petit mal. The two patterns are clinically entirely distinct. Pseudo petit mal does not change into petit mal with increasing age; it usually clears up by seven years of age but in rare cases it is replaced by other seizure patterns. It is a relatively benign disorder.

Petit Mal Variant Discharge

The 2 per second spike-and-wave discharge of the petit mal variant type is a severe disorder of early childhood (Fig. 11). It does not usually have an immediate temporal relationship with clinical seizures, but patients with this type of discharge, as a rule, have frequent severe major convulsions and signs or symptoms suggesting structural damage to the brain (motor or sensory defects and mental retardation). A history of trauma or anoxia at birth is common. This pattern can be caused by encephalitis in infancy; it is almost never caused by a tumor.

Petit Mal Discharge

Generalized 3 per second spike-and-wave discharges of the petit mal type (Fig. 12) are characteristically a disorder of childhood. They are usually associated with epileptic seizures of a special type, namely,

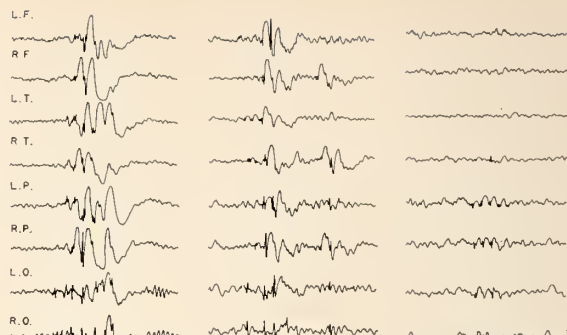


Fig. 13—Three examples of 6 per second spike-and-wave discharges. When the discharges are of high voltage they are commonly slower, 4-5 per second.

brief periods of impaired consciousness (absences) with staring or blinking.

Three per second spike-and-wave discharges of the petit mal type are not specific for any particular etiology. They are rare in cases with a history of trauma or encephalitis. They are almost never produced by a tumor.³¹ In most cases the etiology is unknown. Although it has been suggested that petit mal is due to a hereditary defect,³² a large body of data indicate that near relatives with epilepsy are no more common in the families of patients with petit mal than in the families of persons with other types of epilepsy. Churchill reports a relationship to breech delivery.³³ Petit mal has been called *centrencephalic epilepsy* by Penfield³⁴ and his followers, but there is no conclusive evidence that it originates in the depths of the brain.³⁵⁻³⁶ It tends to clear up with increasing age and is rare in adults. Tridione, Celontin and Zarontin are specific anti-petit mal substances; the last two are the drugs of choice when petit mal and grand mal are both present.

Six Per Second Spike-and-Wave Discharge

Six per second spike-and-wave discharges (Fig. 13) are usually of lower voltage than the classical 3 per second spike-and-wave of petit mal and often have the appearance of miniature petit mal discharges.³⁷ The frequency is not always 6 per second; it varies from 4 to 7 per second; among children it is slightly slower than among adults. It is commonly bilater-

ally symmetrical and diffuse. In some cases it shows best in the frontal and parietal areas but it can appear anywhere and not infrequently is most evident in the occipital areas. In a high percentage of cases it can be precipitated by hyperventilation and it is "activated" by light sleep. However, it is not so exclusively a sleep pattern as 14 and 6 per second positive spiking, for in a higher percentage of recordings it appears in the waking state. As a rule it does not occur (as true petit mal does) in long, regular discharges lasting for 5 or more seconds but rather, in very short bursts lasting less than one second. It may, however, last longer; cases have been observed in which it was continuous, lasting for one hour or more.

Like the petit mal discharge, this pattern is more common among women than among men (almost all other types of discharge are more common among men than among women). Since it shares so many features with the classical 3 per second spike-and-wave of petit mal, it is surprising that there is so little clinical relationship between these two patterns. The six per second discharge is chiefly a late adolescent and adult abnormality. Persons with this disorder do not have petit mal seizures but they are likely to have other types of seizures. Although it is definitely an epileptic pattern, it occurs in a small percentage of normal control subjects (the true petit mal discharge does not). Attacks of dizziness, headache, stomachache, nausea and vomiting are the most common forms of seizure. The relatively high incidence of mental retardation and behavior disorders among patients with this pattern is in marked contrast with their low incidence among patients with the classical electroclinical forms of petit mal. The symptoms associated with 6 per second spike-and-wave discharges most nearly resemble that of 14 and 6 per second positive spiking.

The 6 per second pattern is not usually associated with a gross lesion; it is rare in cerebral palsy. The most common cause is trauma. This disorder tends to decrease with increasing age. The associated episodic symptoms usually respond well to

anticonvulsant medication (they do not respond well to anti-petit mal medications).

Nonspecific Diffuse Spike Discharges

Diffuse or generalized spikes or spike-and-wave discharges that are not classifiable as hypsarhythmia, pseudo petit mal, petit mal variant, petit mal discharges, 6 per second spike-and-wave, or fronto-parietal spike-and-wave discharges, have been classified as *nonspecific diffuse spike discharges*. This is a catch-all category which, however, turns out to be surprisingly homogeneous. It is found predominately in young epileptics (only 10 percent of patients with this pattern are nonepileptic). The etiology is usually unknown.

Multiple Spike Foci

Multiple foci of spike seizure activity (usually in both hemispheres) are most common in infancy and early childhood. This abnormality is a frequent sequel of hypsarhythmia and is one of the most characteristic findings in cases of cerebral palsy, particularly when associated with epilepsy. It correlates highly with epilepsy and with mental retardation. Though nonspecific as regards etiology, it is more commonly caused by encephalitis and by perinatal injury than by postnatal trauma.

Hemisphere Spikes

Focal seizure activity which involves the greater part of one hemisphere but which is confined to a single hemisphere is most common in infancy and early childhood. In the great majority of cases it is associated with epileptic manifestations, and it is highly associated with mental retardation and cerebral palsy. Perinatal injury and encephalitis are the most common causes.

Occipital Spike Focus

During infancy and early childhood a focus of spike activity in the occipital area is the most common type of spike focus; it is an almost exclusively juvenile focus.^{2, 38-40} In only two-thirds of cases are clinically recognizable seizures present; thus it is one of the least epileptogenic of the spike foci. It is common among children and infants with a history of premature birth. This finding is likely to be associated with

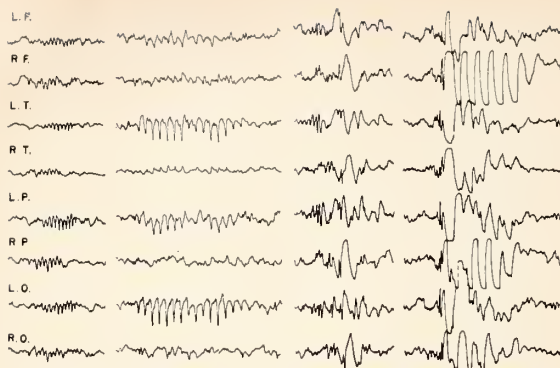


Fig. 14—Examples of 14 and 6 per second positive spiking in children.

eye defects such as strabismus and congenital cataracts and particularly so when retrolental fibroplasia is present. Although prematurity and perinatal injury are important causal factors, occipital spikes can result from encephalitis and postnatal trauma. With increasing age occipital spiking tends to disappear or shift to the mid-temporal area.⁴¹

Mid-Temporal Spike Focus

Spike activity in the mid-temporal area is the characteristic spike focus of children 5 to 12 years of age. It is highly epileptogenic and is usually associated with a history of convulsions. Children with this type of focus commonly have focal convulsive seizures, usually confined to the face, but sometimes spreading, as a Jacksonian seizure, to other parts of the body. Behavior disturbances and nightmares are more commonly associated with mid-temporal spiking than with negative spiking elsewhere. (However, these symptoms are most commonly associated with 14 and 6 per second positive spiking.) With increasing age mid-temporal spiking tends to disappear or to become converted into 14 and 6 per second positive spiking or into an anterior temporal spike focus.⁴¹ Mental retardation and cerebral palsy are the most outstanding nonepileptic concomitants of mid-temporal spiking. Birth injury is slightly more common than any other causes, but in most cases the etiology is unknown.

Frontal Spike Focus

A spike focus in the frontal areas, predominately on one side or the other, or bi-

laterally independent is readily distinguishable from bilaterally symmetrical frontoparietal spike-and-slow-wave discharges. The distinction is important because the former is only a slightly less juvenile pattern than mid-temporal spiking, whereas the latter is almost exclusively an adult pattern. Frontal spiking and mid-temporal spiking are equal as regards their association with epileptic seizures. They are more highly associated with clinical epilepsy than any other types of spike focus, except the anterior temporal. The outstanding nonconvulsive concomitants of frontal spiking are mental retardation, cerebral palsy and behavior disorders. The etiology is usually unknown. A history of encephalitis or birth injury is more common than among a matching clinical group with normal electroencephalograms.

Parietal (Central) Spike Focus

The portion of the brain covered by the parietal electrodes is the central area, or more precisely, the outer surface of the mid-portion of the central area. Parietal spikes are commonly bilateral and synchronous. In some cases, however, they are either unilateral or maximal on one side or the other (unequal spread to the temporal areas is a form of lateralization). Such spiking is more common among children but it occurs at all ages. Surprisingly enough, it is less usually associated with clinical epileptic manifestations than an anterior temporal, mid-temporal, or frontal spike focus. The outstanding nonepileptic symptoms are cerebral palsy and mental retardation; these are more commonly associated with parietal spiking than with any other single area focus. Birth injury is an especially frequent etiology.

Fourteen and Six Per Second Positive Spikes

Fourteen and six per second positive spikes (Fig. 14) are classified among the focal spike discharges because, though commonly bilateral, they usually appear independently in the two hemispheres and are usually maximal in the temporo-occipital areas. They presumably spread to these areas from the depths of the brain.

Fourteen and six per second positive spiking is an abnormal sleep pattern, but it occurs in approximately 20 percent of unselected school children. It is often asymptomatic, but correlates positively with one or more of the following: episodes of pain (particularly headache), dizziness, nausea, vomiting, palpitation of the heart, difficulty in breathing, attacks of sweating, and other visceral and vegetative disturbances and with episodic emotional instability (particularly rage). These symptoms contrast with those that ordinarily occur in the classical forms of epilepsy.⁴²⁻⁴³ They are what might be expected to result from an epileptic discharge in the thalamus and hypothalamus. Convulsions occur rarely and when present are not usually as severe or as frequent as in the classical forms of epilepsy. The incidence of "atypical seizures" or "questionable epilepsy" is approximately twice as high as in a matching clinical group with normal electroencephalograms. Fourteen and six per second dysrhythmia is the most common and also the mildest and least specific (as regards its clinical manifestations) of all the forms of epilepsy.

This disorder tends to clear up with increasing age. When associated with episodic symptoms, these can usually be alleviated or eliminated with anticonvulsant medication. The etiology is nonspecific. Gross lesions are uncommon; trauma is the most usual assignable cause but in the majority of cases the etiology is unknown.

Psychomotor Variant Discharge

The psychomotor variant discharge is a rare but characteristic pattern that appears during drowsiness (Fig. 15). It consists of bursts of 4 to 7 per second, rather square-shaped waves, which are notched by a rounded component having approximately half the duration of the square wave.⁴⁴ Sometimes this component is so strongly expressed that the square wave appears to be made up of paired waves with a frequency of 8 to 12 per second. The mid-temporal and the anterior temporal regions are usually the site of the discharge. Although sometimes unilateral, it is usually

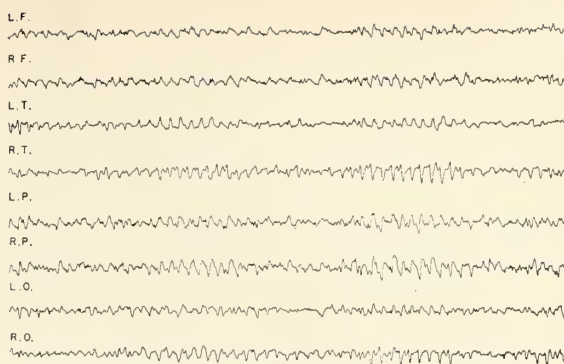


Fig. 15—Bilateral psychomotor variant discharges.

bilateral but independent. Rarely does it appear bilaterally synchronous. It can usually be picked up from electrodes on the ear lobes, and an "active ear" is usual with this pattern. In order to clearly demonstrate this pattern, a shift to some reference other than the ear lobe, for example, the nose, chin, neck, or chest is often necessary.

Persons with this abnormality are more usually adults than children, but a high proportion are adolescents. A clear cut history of epilepsy is slightly more common than in a matching clinical group with normal electroencephalograms, but this pattern is not highly epileptic in the classical sense. The outstanding symptoms are much like those occurring among patients with 14 and 6 per second positive spikes and 6 per second spike-and-wave discharges, namely, dizziness and headache, nausea and vomiting, paresthesias and, also, behavioral and psychic disturbances. Trauma is the most common presumptive cause.

Anterior Temporal Spike Focus

A focus of spike seizure activity in the anterior temporal lobe is the most usual type of epilepsy among adults; such disorder is rare among young children.² Convulsions are common in such cases, but trance-like attacks and confusional episodes are more common. Anterior temporal spikes are the most highly epileptic of all single area spike discharges; in over 90 percent of cases they are associated with clinically diagnosable seizures. The behavioral manifestations with anterior temporal spiking consist characteristically of relatively complex, more-or-less purposeful movements.

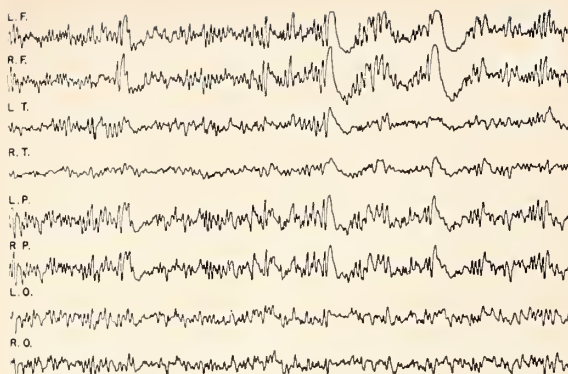


Fig. 16—Fronto-parietal spike-and-wave activity.

Because these appear to originate at the "psychic level" anterior temporal seizures have been called *psychomotor seizures*. Illusions of familiarity and unfamiliarity (*déjà* and *jamais-vu* sensations) and olfactory hallucinations of the classical uncinate type occur in a small percentage of cases.

Persons with anterior temporal spiking often have more-or-less continuous personality disorders which lead to their being labeled "neurotic," "obsessive," "compulsive," or even "psychotic." Such psychiatric disorder and behavior disturbances are often more severe and more handicapping than the patient's epileptic seizures. They are nonepisodic and independent of the epileptic disorder; they are often intensified when the seizures are controlled. Impairment of memory is an especially common complaint among patients with anterior temporal spiking. The only electroencephalographic abnormality more commonly associated with psychiatric symptoms is the mitten pattern.

The etiology of anterior temporal spiking is nonspecific and usually unknown. It is in general more persistent than other types of spiking; it does not tend to clear up with increasing age. It is one of the most difficult forms of epilepsy to treat with the currently available medication. In resistant cases temporal lobectomy should be considered.

Many bipolarists do not recognize that there is a clear and important distinction between focal spiking in the mid-temporal lobe and in the anterior temporal. They use the term, *temporal lobe epilepsy of adults*

to cover what we call psychomotor, or anterior temporal lobe epilepsy.

Small Sharp Spikes

Small sharp spikes are usually bilaterally independent. As a rule they are widespread, but predominate in the temporal and frontal areas. They are not so likely to be associated with an "active ear" as the classical high voltage spikes of the psychomotor type (anterior temporal spiking). Small sharp spikes are found mainly in adults, and they often occur in association with, but independent of, anterior temporal spiking. This is an epileptic pattern, but it occurs occasionally among supposedly normal adults. The symptoms are rather nondescript: dizziness and headache, nausea and vomiting, and various neurological disturbances are more commonly associated with anterior temporal spiking. The etiology is usually unknown. Small sharp spikes clear up more commonly than anterior temporal spikes. When they are the sole abnormality, the seizures associated with them, as a rule, are not very severe or frequent. The response to anticonvulsant drugs is generally good.

Fronto-parietal Spike-and-Wave Discharge

The fronto-parietal spike-and-wave discharge (Fig. 16) is an abnormal pattern of drowsiness and light sleep; only rarely does it appear in the awake recording. It resembles the mitten pattern except that its fast component is definitely spiky, usually with a duration of less than $1/10$ of a second. However, transition forms are common, and in some cases one cannot distinguish clearly between fronto-parietal spike-and-wave discharges and B-mittens. Both are almost exclusively adult abnormalities; they are never seen in young children. Unlike mittens, however, fronto-parietal spike-and-wave discharges are clearly an epileptic abnormality; in 80 percent of cases clinically evident epileptic seizures are present. Psychosis is uncommon unless mittens are also present. There are no outstanding nonepileptic symptoms. Tumor and vascular disease are almost never associated with fronto-parietal spike-

and-wave pattern. Trauma is the most usual cause.

Disordered Sleep Patterns

A waking electroencephalogram may be entirely normal and yet during sleep it may be totally abnormal, or vice versa. Spike discharges and seizure patterns of all types are more likely to occur in sleep than in the waking state. Normal sleep activity is highly patterned; certain patterns are to be expected at certain ages and at certain stages of sleep. The alteration or absence of these and their replacement by other activity are classified as *disordered sleep patterns*. Sometimes the replacing activity looks strikingly abnormal but sometimes it merely has an unvarying, unpatterned and disorganized appearance. In rare cases activity is the same awake and asleep. Even though the patient falls into a state that is behaviorally sleep, with eyes closed, unresponsive (but arousable) with slow and deep respiration or snoring, and with muscle activity decreased or absent, the electroencephalogram may remain unchanged from that which was present when he was awake.

The most extreme sleep abnormalities, from an electroencephalographic point of view, are those seen in craniostenosis, hydrocephalus, cerebral palsy, and in other conditions where deep cerebral structures are damaged. Examples of the last mentioned are cases of deep cerebral tumor, and cases with degenerative or cerebrovascular disease involving the central gray masses. In such conditions not one but a great variety of abnormal sleep patterns occur including such specific disorders as extreme spindles, asynchrony, and mit-

Periodic Bursts of High Voltage, Extremely Slow Activity

High voltage bursts of slow waves with a frequency of 1 to 6 per second occurring periodically (Fig. 17) are a rare but distinctive pattern that appears in both awake and asleep recordings. It occurs in certain severe, deteriorating neurological disorders, often in immediate temporal association with brief hyperkinesia, which may

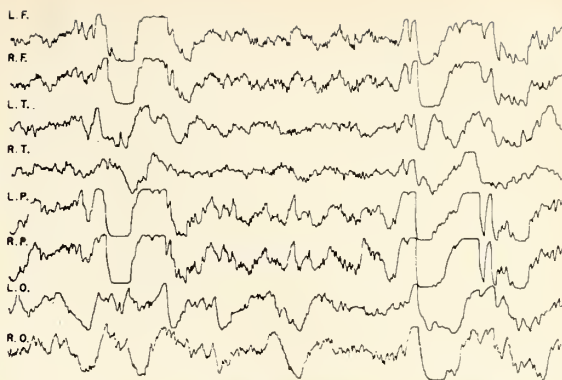


Fig. 17—Periodic brief episodes of extremely high-voltage, extremely slow (1 to 1½ per second) activity in all areas.

take the form of periodic sudden torsion spasm (i.e., the spasms are synchronous with the bursts of periodic slowing). The pattern is so slow and so widespread that it might be taken for a movement artifact if identical patterns did not occur in the same patient without movement, particularly in sleep. This pattern is most commonly seen in chronic subacute leukoencephalitis, and it corresponds closely to that which Radermecker⁴⁵ considers pathognomonic for this disorder. An identical pattern is seen occasionally, however, in lipodystrophy. It seems likely that, just as hypsarhythmia and petit mal variant are not caused by a single etiology and are not associated with a particular structural lesion, periodic slow bursts probably are not an altogether exclusive specific characteristic of this particular histopathologic entity, namely, subacute leukoencephalitis. It correlates with periodic spasmodic athetoid movements and also with irreversible motor and intellectual deterioration. It is as specific as any pattern in electroencephalography. It has a very bad prognosis; the course is downhill without significant remissions and it invariably ends in death.

Summary and Conclusion

When all technical requirements are met and when interpretations are made by a qualified electroencephalographer who bases his opinion on large numbers of uniformly classified normal and abnormal cases, electroencephalography acquires a power and range that places it in the top

rank of diagnostic techniques. The significance of specific findings can be stated in terms of the expectation of occurrence of various types of epileptic seizure and various neurological and psychiatric symptoms. Though nonspecific as regards etiology, electroencephalographic studies, particularly when repeated at appropriate intervals and combined with clinical and other laboratory data, can aid in establishing the etiologic diagnosis.

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ACUTE SALICYLATE INTOXICATION: EFFECT ON THE DIRECT EOSINOPHIL COUNT

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case report

THE ABILITY of the human body to survive unusually large doses of salicylates is illustrated by a recent patient. Many cases of salicylate poisoning have been reported without coincidental studies of the eosinophils in the peripheral blood.

Report of a Case

A woman of 26 years was brought to the Cook County Hospital, Chicago. She had swallowed 164 tablets of aspirin (54 gm.) over a period of two hours. She had received electric shock treatments for schizophrenia three years previously. Immediately prior to the ingestion of aspirin, her parents noted laughing without cause and some confusion. The stomach had been lavaged at another hospital.

At 9:00 P.M., on admission, she was a semicomatose, moderately obese, confused individual with Kussmaul respiration (increased frequency and depth), "Salicylate Dyspnea," her temperature 99.8, pulse rate 112 per minute, blood pressure 118/74 mm., respirations 38 per minute. Her skin was reddened, warm and moist. The pupils reacted to light. The conjunctivae were reddened. The corneal reflex was present. The heart and lungs were normal with the heart tones clear. The abdomen offered no abnormalities. There were no pathological reflexes, or signs of meningeal irritation. The deep reflexes were increased equally.

A presumptive diagnosis of salicylate intoxication and paranoid schizophrenia was made on the history, physical, and the finding in the urine of a four plus ferric chloride reaction not disappearing on heating. The patient was vomiting. She

was given the universal antidote and sodium bicarbonate after stomach lavage. 1000 cc of sodium lactate was given intravenously. Sodium bicarbonate retention enema was attempted. The patient could not retain it. A Levine tube was passed and 250 cc of sodium bicarbonate given in orange juice. Penicillin (600,000 units) was given prophylactically. At 2:00 A.M., eight hours after admission, her face was flushed. The patient was still drowsy.

The next day the patient was still stuporous. Her breathing was of the Kussmaul type, 30 per minute. The salicylate level was 68 mg. per cent, blood pH was 7.54 and the CO₂ combining power was 42. Carbon dioxide inhalation was instituted.

On the third day, she was more alert and cooperative; the salicylate level was 41.5 mg. per cent.

Daily eosinophil counts made by Pilot's¹ method demonstrated an initial depression of over 50% (62). The count gradually increased to 180 as the patient improved.

On the fourth day, she retained water and food. She was oriented as to time and place. The salicylate level was 15.0 mg. per cent. She continued to improve and was discharged to another hospital. A pruritic eruption over the back and buttocks was relieved by Benadryl. She was given several insulin shock treatments with some benefit. Reserpine and Chlorpromazine were administered for a short time before she was discharged as improved.

Comment

This case illustrated typical symptoms of salicylate intoxication: salicylate dyspnea, vomiting, sweating, hyperactive reflexes, reddened mucous membranes and lethargy with confusion. The treatment by stomach lavage with bicarbonate, intravenous sodium lactate, and CO₂ inhalations increased the elimination of salicylates through the urine.

The azotemia regressed to normal eight days

From the Arthritis Clinic of the Cook County Hospital, Eugene Traut, Director.

Dr. H. Chor co-operated in the preparation of this paper.

TABLE 1

Laboratory Findings					
Date	Urinalysis	Blood Count	CO ₂ Com- bining Power	Non- protein Nitrogen	P.S.P. Excretion
Dec. 13	Sp. Gr. 1006 Acetone—Tr. Albumen—Tr. Ferric Chloride 4+		42		
Dec. 14		W.B.C. 24,400 Poly. 84 Eos. 0 Neut. 2 Lymph. 5			
Dec. 15			24	78	
Dec. 17				34	14%
Dec. 20	Sp. Gr. 1017 Albumen—Tr. Acetone—0				10:25 60% 11:15 25%
Dec. 21		W.B.C. 11,350 Poly. 68 Eos. 1 Lymph. 31	31		
Dec. 23				14.5	

TABLE 2

Laboratory Findings				
Date	Salicylate Levels Mg%	Circulating Eosinophils	Liver Function Tests	
Dec. 14	68			
Dec. 15	41.5	62	Cephalin flocculation	0
			Thymol turbidity	1.4 (MacLagen)
			Gamma Globulin	0.96
			Alkaline Phosphatase	2.5
			Icterus Index	7.0
			Creatinine	3.6
Dec. 17	15			
Dec. 18	2.5	120		
Dec. 19	1.0	180		
Dec. 20	1.0	120		
Dec. 21	0	121		

TABLE 3

Laboratory Findings				
Date	Bromsul-phalein	Minerals		Kahn
Dec. 17	7%			
Dec. 15		Chloride	96	Negative
		Sodium	141	
		Potassium	3.1	
		Phosphorus	3.5	
Dec. 23				225 mg.

after admission. The bromsulphalein retention points to persisting liver damage.

The marked eosinopenia in this case interested us in view of our recent studies regarding the effects of therapeutic doses of salicylates on the eosinophil level.² In our experience, a regular effect of salicylates in the total number of eosinophils is not predictable. A steroid-like effect has been advanced to explain beneficial effects of salicylates in many illnesses. The induced eosinopenia in this patient is interpreted as due to increased liberation of steroids due to stress of a toxic dose of a drug rather than to any steroid-like effect of salicylates.

Conclusions

Salicylate intoxication following the ingestion of 54 gm. of aspirin produced azotemia and liver damage. Daily eosinophil counts showed that salicylates of this magnitude have an indirect steroid-like action by affecting the pituitary and adrenal glands.³

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CHECK SPRAY SCHEDULE

Pesticide residues in frozen foods are a problem requiring unique controls where raw agricultural commodities of a perishable nature are purchased. FDA and state regulatory and surveillance programs on pesticide residues on raw agricultural commodities reveal that only a small incidence of samples bears illegal residues. The prudent frozen food packer, however, does operate his own competent control system. When feasible, this includes a close check of a grower's spray schedule supplemented by use by the laboratory of rapid screening methods to test samples of crops shortly before or upon delivery to the plant. Since FDA has pioneered in the development of many of the currently used pesticide residue methods, we will assist your Association or individual firms which wish to learn more about rapid screening and multiple detection methods. "*Public Health News*," September, 1964.

DIAGNOSTIC RESPONSIBILITY TO THE NEUROTIC PATIENT

THE SPECIAL PROBLEM OF THE PATIENT WITH PERSISTING SYMPTOMS

Jerome F. Strauss, Jr., M.D./chicago

THIS PAPER IS PROMPTED by recent experience with three patients in whom multiple examinations by competent physicians resulted in erroneous diagnoses because of failure to consider the possibility that a patient with an obvious emotional disturbance could also be harboring an organic disease which was, in fact, the true cause of the symptoms. The difficulty in each case was compounded by negative laboratory data strongly confirming the overwhelming impression of functional disease.

When a patient enjoying good health and free of hypochondriasis comes to the physician with a complaint, the doctor may have the gratifying experience of reassuring him that he has become unduly alarmed over a minor abnormality. The opposite situation obtains, however, in the individual who is continually suffering from symptoms with little or nothing in the way of objective findings, and who also has emotional problems which could readily account for the clinical picture. Thus, the existence of stresses in the home or at work, and the established presence of recognized psychosomatic stigmata such as migraine or ulcer in the past or present may lead the clinician astray.

The most conscientious physician is not infallible. There is not one who has not failed to recognize disease, which in retrospect appears impossible to have missed, and no one who has not been jolted to the realization of his lack of omniscience by the patient whose vague symptomatology suddenly crystallizes into a disease to which the physician has himself unwittingly contributed to the delay in diagnosis.

The cases briefly summarized here eventually represented three entirely different diagnoses, yet initially, all had a number of features in common. All were women; all were intelligent, cooperative, and had been under close observation for long periods of time. In each case, there were obvious emotional factors which seemed to correlate with the symptoms, and laboratory studies were uniformly misleading in their failure to demonstrate pathology. Finally, in all cases, surgical exploration furnished both the correct diagnosis and the cure.

Case Reports

Case 1: A 25-year-old woman was first seen on February 23, 1961. Her past history revealed that she had been diagnosed at one time as having thyrotoxicosis, because of weight loss, tachycardia, fatigability, nervousness, insomnia and sore throat.

Her major problem, however, was the occurrence of what she called "spastic attacks," characterized by severe upper abdominal cramps. These attacks had begun approximately ninety days following an uncomplicated appendectomy at age sixteen. The episodes sometimes occurred as often as once a month, and were described as severe cramps in the epigastric area radiating to the back and often associated with nausea. The patient was admitted to a hospital on several occasions, where the attacks would subside without any diagnosis being made. Interim investigations of the gastrointestinal tract, pancreas and urinary tract were repeatedly normal. It was obvious to several observers that the patient had severe emotional problems, and a psychiatric approach was recommended. During the year or so in which she was under treatment, the abdominal pains were definitely less frequent and severe, and the therapy was discontinued. The symptoms soon recurred in their former intensity, however, and it was at this point in the course of her disease that the patient was first seen. Initial examination revealed no significant abnormalities. The patient was quite thin and the abdominal wall flaccid, making thorough examination simple. Because of the repeated prior negative investigations and the obvious emotional overlay, it was decided to observe the patient for a while with a bland diet and sedative-antispasmodic preparations before recommending any further work-up. The attacks were noted to continue more or less unchanged. There was poor response to large doses of narcotics, although nitroglycerine sublingually was sometimes helpful. It was noted that the pain episodes were followed by several days of residual soreness in the abdomen and a tendency to distention, though examination was at all other times completely negative.

In July, 1961, the patient had her worst episode of upper abdominal pain in several years. There were recurring cramps about every five minutes, with no response to large oral doses of codeine and finally, parenteral meperidine and anticholinergics. Examination revealed only a little upper abdominal distention and vague tenderness. The pain gradually subsided after several hours. It was at this point that the decision was made to recommend laparotomy as a diagnostic procedure. The patient was referred to a surgeon for consultation and he independently came to the conclusion that exploration was the only tool which had not been employed.

On August 15, 1961, operation revealed hypertrophy and spasm of the pyloric musculature, which, however, was seen to periodically relax completely. It was thought at first that this could have been the source of the pain, but further search demonstrated that in the vicinity of the terminal ileum and cecum, dense, postoperative adhesions had entrapped a loop of small bowel and created a volvulus. The remainder of the abdomen was completely normal. The adhesions were separated, and recovery was uneventful.

Since surgery, the patient has continued to have emotional problems and a variety of complaints, but there have been no recurrences of the severe abdominal pain. Occasional mild epigastric distress has been noted, but it responds readily to anti-spasmodics and is presumed to be related to the pyloric muscle changes noted at surgery.

Case 2: A 53-year-old pediatric nurse was first seen July 8, 1963, with complaint of supraumbilical cramps which were occurring with increasing frequency. The pain was referred both upward into the throat and down toward the lower abdomen. The episodic pains were sometimes associated with nausea, and were followed by residual soreness. The patient also gave a long history of bronchial asthma and intractable, severe migraine. Three years previously, she had undergone a hysterectomy and appendectomy. At that time, she was found to have endometriosis. One year before being seen, the patient stated that diagnoses of "colitis," hiatus hernia, and duodenal ulcer had been made, and she had been placed on a bland diet and anti-spasmodics.

Initial examination revealed a somewhat obese female in no acute distress. There were no significant findings except for a slight tachycardia and some tenderness in the right upper quadrant. Because of the previous exhaustive work-up, it was decided to observe the patient for a time. About one month later, a severe recurrence of the pain again brought the patient in. Physical examination was negative. An x-ray of the stomach and small bowel revealed a prominent hiatus hernia, but no other disease.

The symptoms again subsided for another month, but in October 1963, the pain recurred in even more severe form. Except for some poorly localized abdominal tenderness, examination was again negative. The pains failed to respond to large doses of analgesics and antispasmodics. It is of interest that the patient was sure that she could distinguish this pain from the distress which she associated with the hernia. Because of the disabling character of the pain and the unexpected appearance of a fever, the patient was admitted to the hospital. In the hospital, a colon x-ray was normal. The fever continued but physical findings were restricted as usual to generalized mild abdominal tenderness. The white blood count and the differential remained normal. It was felt that surgical exploration was indicated, and on October 22, 1963, a laparotomy was performed. When the abdomen was entered, it appeared normal except for the right lower quadrant, where there appeared to be an ileitis and an enterocenteric fistula approximately four inches from the ileocecal valve. This had produced a partial small intestinal obstruction. Approximately 85 cm. of the small intestine, the cecum and a small segment of ascending colon were resected, and an end-to-end anastomosis performed. Grossly, it was suspected that the patient probably had a regional enteritis, but microscopic examina-

tion revealed the pathology to be endometriosis. The postoperative course was not smooth, being marred by persisting abdominal pain and intractable diarrhea. Following discharge from the hospital, the patient looked much better, but continued to complain of a diarrhea and abdominal pain which was well localized to an area just to the right of the umbilicus. It was observed that any medication taken for migraine attacks seemed to aggravate the pain. The entire gastrointestinal tract was again x-rayed, with negative results. Because of the pathology found at surgery, hormone therapy was tried, with equivocal results. The patient was quite discouraged and the increasing abdominal distress finally became impossible to manage. Another surgical exploration was decided upon, and on August 18, 1964, a second laparotomy was performed. There were dense adhesions between the omentum and the abdominal wall, but no evidence of a recurrent obstruction, and the anastomosis was functioning perfectly. Since discharge, the patient has had no further significant abdominal distress, but the diarrhea remains unchanged.

Case 3: A 29-year-old housewife was first seen in 1951 with nausea, vomiting, epigastric distress and fat intolerance. She also gave a history of severe headache associated with menstrual periods or emotional upsets. Her home life was quite disturbed, with constant conflict and tension.

During the next three years, the patient had variable symptoms involving virtually every organ system in the body. In 1954, oral cholecystography revealed cholelithiasis, and on July 28, 1954 a cholecystectomy was performed. At that time, exploration of the abdomen was carried out and revealed no pathology except for dense adhesions in the pelvis from old inflammatory disease. There was an uneventful convalescence, but recurrent symptoms necessitated hospitalization again for intravenous cholangiography and further investigation of the intestinal tract. All studies were negative except for a deformity on the lesser curvature of the duodenal bulb which was concluded to be due to spasm. Diet and antispasmodics were prescribed with variable benefit. In 1957, it was necessary to hospitalize the patient for intractable migraine. The persistent gastrointestinal symptoms led to further x-rays, which were interpreted that time as normal, as they were when repeated again in 1958.

During the next five years, the patient was never more than a few weeks without symptoms, most often related to periods of family dissension. In 1963, she was admitted to the hospital for minor injuries sustained in an automobile accident. Because she was undergoing some of her recurrent gastrointestinal symptoms at the time, the x-rays were again repeated, this time revealing a pyloric canal ulcer. Response to very strict dietary management and anticholinergics seemed good at first, but about this time she complained of amenorrhea and gradual distention of the abdomen. It was

associated with nausea and inability to eat anything except a few prepared baby foods. It was determined that she was not pregnant, and the surgical consultant did not feel that the ulcer could be responsible for the distention. On March 24, 1964, the patient was explored. The ulcer was noted, but it appeared to be insufficient to cause the symptoms. When the surgeon began to perform a gastroenterostomy after resection of a portion of the stomach, he discovered that what he had taken to be jejunum was actually a segment of the ileum. Careful search revealed that the proximal small intestine was in an internal hernia sac, the result of failure of the peritoneum to fuse posteriorly. It was immediately apparent that intermittent entrapment of the intestine within the sac was producing variable degrees of intestinal obstruction and was the cause of the symptoms. The hernia was corrected and the anastomosis was performed without difficulty. Since surgery, the patient has remained free of intestinal tract symptoms, although her personal problems have continued unabated.

Discussion

The foregoing cases represent classical examples of the eternal dilemma which the physician faces when dealing with a diagnostic problem. What constitutes adequate pursuit of the symptoms in a given case? At what point can the physician feel with certainty that further investigation will not prove fruitful? As long as the human element exists in medicine, there will be the chance of human error. Arbitrary excesses of diagnostic procedures are not the solution, since they may fail to demonstrate the pathology or even mislead the clinician, as illustrated above. In addition, the patient is subjected to both physical and psychological trauma. Certainly, not every symptom in every patient will be explicable in the light of present day medical knowledge, but it is becoming increasingly obvious that as we gradually uncover the true complexity of bodily functions which were once thought to be thoroughly understood, that fewer and fewer symptoms will be relegated to the realm of the psychosomatic.

In order to distinguish the patient with true organic pathology from the purely functional complainer, perhaps the most important aid, and the most difficult to master, is to maintain an open mind at all times, a high index of suspicion. The physician must be constantly alert to the appar-

ently insignificant item which may prove to be the key which unlocks the problem. This may be an isolated laboratory result or a physical finding which could be consistent with organic disease. There should be a constant endeavor to correlate the symptoms with the physiology of the area involved. If such efforts fail, then the value of surgical exploration must be weighed.

At this time, the physician must evaluate the probability that the patient can be explored with reasonable certainty that the pathology, if any, will be demonstrated. The patient must not be simply turned over to the surgeon with instructions to see what he can find. The operator must be thoroughly briefed in advance, and prepared to methodically explore the abdomen. As illustrated in the third case, this involves careful identification of all organs. Thus, the patient in whom surgery must be a quick "in-and-out" procedure is not a suitable candidate, nor is the obese individual or the one in whom other factors may exert a limiting effect on any value to be gained from the

surgical exploration. In both the second and third cases, the value of a second exploration for persistent symptoms is demonstrated.

Conclusion

Although the inference might be drawn from the above discussion that surgical exploration is always the solution to the difficult diagnostic problem, it would obviously be incorrect to arbitrarily apply this policy in all cases. It must be stressed that this avenue of approach should be considered only when all other appropriate diagnostic measures have been fully utilized, not as a measure of desperation. There should be a rational justification which transcends the risks which surgery inevitably entails. When this circumstance exists, the physician should not hesitate to offer his neurotic complainer this opportunity for relief and restoration to health.

It is suggested that a sober review of certain problem cases is in order, for there must be many patients similar to the above who remain as yet undiagnosed.

PLASTIC SURGERY

Today the trained plastic surgeon offers satisfactory correction in the majority of congenital deformities. These include the face and hand abnormalities and practically all skin lesions. The restoration of bony contours of the skull and creation of specific features such as nose, ears or eyelids is less satisfactory but generally good improvement results. With traumatic lesions, early surgical definitive repair is essential to minimize or avoid later tedious plastic interventions. It is becoming increasingly clear that in order to avoid personality and behavior problems plastic surgery should be available, at the time of the initial trauma. Secondary repairs must be carefully planned as to time and procedure. These are more difficult and are frequently less satisfactory.

Complete rehabilitation includes the proper preoperative and postoperative atmosphere, both in the hospital and home environment. Postoperatively, a period of reaction and adjustment to the new appearance must be expected. The proper physician-patient relationship is important to effect lasting physical and psychologic improvement. In this atmosphere the disfigured adolescent can be restored to his normal place in society. *The Journal of the International College of Surgeons*, September, 1964.

RECENT ADVANCES IN DERMATOLOGY

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DERMATOLOGY HAS PARTICIPATED and shared in the recent tremendous advance and growth of medical knowledge. A review of only the past year's literature uncovers a great volume of new developments in the basic sciences as well as the clinical and therapeutic features of cutaneous medicine. A few of these will be listed and later described. Experiments showed that the keratin layer acts as a reservoir for topically applied corticosteroids, and that these later are absorbed through the skin. Griseofulvin can derange porphyrin metabolism. New syndromes were described, among them erythropoietic protoporphyria and chloroquine neuro-myopathy—still another toxic manifestation of this antimalarial. Surgical eradication was advocated for excessive sweating. Data suggest that children suffer more frequently and easily from primary irritants. Bithionol, a bacterio-static in numerous cosmetic and soap preparations, is a photosensitizer. A new test described how to use leucocytes to show immunologic competence in delayed

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Medical Progress

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hypersensitivity. It was shown that sulfones injure erythrocytes, and that tetracyclines may yellow the teeth. Intradermal nevi may contain junctional elements, and these components may have serious possibilities. Radiation may be effective in some melanomas. Exfoliative cytology and the aldehyde fuchsin stain may aid in diagnosing Paget's disease of the breast. APC virus may produce erythema multiforme; and there may be coagulation deviations in epidermolysis bullosa. Cataracts may occur with alopecia universalis; and severe central nervous system changes with malignant papulosis of Degos. Cryoglobulins are sometimes present in acrodermatitis chronica atrophicans. Monilial infection can cause tinea capitis, ophthalmitis, and cheilitis. Investigators demonstrated the virus of milker's nodule, and the presence of humoral antibodies in molluscum contagiosum. Besides these, there were many other advances and demonstrations too numerous to mention. Only some of these will be enlarged upon here.

That a relationship between dermatomyositis and various kinds of malignancy, especially carcinomatosis, exists has been suspected a long time.² A search for underlying malignancy should be made, there-

fore, in all cases of dermatomyositis. In reported series of this collagen disease a varying but impressive percentage of patients was found to have visceral cancer, such as of the lungs, ovaries, and other internal organs. Serum enzyme levels of the transaminases and aldolase are generally increased when the myositic phase of the disease is prominent. Both are useful laboratory determinations in diagnosis and as a guide in following therapeutic response.³

Recently, Shelley and co-workers devised an *in vitro* test procedure in which degranulation of leucocytes serves as an index to recognize competence for immediate allergic hypersensitivity, especially urticaria and anaphylaxis. This test promises to enable the clinician to specifically define what may or could be a responsible antigen or antigens.⁴ To make the test practical, and increase accuracy, proper laboratory preparation and some training become prerequisites. Drug sensitivities, such as to penicillin and sera, may be discovered without endangering the patient. The procedure may be useful for predictive purposes in screening applicants for research purposes. All its possibilities are yet to be discovered.

Hair problems have always been of prime concern to dermatologists, not to say their patients. The world over, practitioners have been aroused and made aware of an apparently new kind of diffuse alopecia of the scalp in young women. It may occur also among older ones. Neither economic nor social distinction is present. Despite much investigation and inquiry regarding this type of hair loss, its cause remains unknown, and thus far no therapy avails.⁵ Alopecia areata, too, remains an enigma. Poorer prognosis goes with youth (children worst of all) and extensiveness of defluvium. Its simultaneous appearance in some families suggests to some the possibility of contagion as pathogenesis. Hair loss is almost always closely associated with considerable emotion, even though one may discount the causal connection of the latter. For comforting the patient, some psychotherapy becomes necessary, and at times one needs the help of the psychiatrist (a

port of rescue for the practitioner). We can be thankful for wigs, too. One cause of alopecia is less prevalent—ringworm or fungus infection of the scalp—thanks to griseofulvin. Nevertheless, this godsend needs to be used with some discrimination and sophistication.

Hypertrichosis, other than the primary idiopathic varieties, is almost always of endocrine origin, though errors of metabolism, such as porphyrias, may be responsible. This is one sector where we may look hopefully to the near future for more light and help. Heredity, gene-determined syndromes, the effects of harboring malignancy, and heretofore unsuspected concomitants and prerequisites are all probabilities. Measuring primary levels of 17-ketosteroids, hydroxysteroids, androgens, estrogens, pituitary tropic hormones, and thyroid function studies, are all useful, even mandatory, in determining if a specific and correctible, endocrinopathy exists. The practitioner needs all his arts: good history taking, physical examination, and laboratory help.

True malignant melanoma rarely occurs in children; but what more often passes as such is a purplish red tumor, the so-called juvenile melanoma of Allen and Spitz, a kind of benign compound nevus. Its prognosis is good; but there is no room for guessing; for only biopsy and careful histologic study prevents regrets. When the shield of puberty is gone, what looks like melanoma is less apt to deceive; and furthermore, there is no excuse for temporising with this deadly growth, despite its disarmingly small and insignificant appearance. If in doubt, the microscope should be the arbiter. If the lesion is indeed a melanoma, it is our opinion that surgery should be the preferred form of treatment. Some recent reports, though, are more encouraging about radiation of melanomas than our experience seems to justify.

A rapidly growing, firm tumor with a central rough, wart-like, keratotic plug, found most commonly on exposed parts, and histologically appearing as a low grade squamous cell epithelioma, is now labeled keratoacanthoma. Evidence points towards

a viral origin. The growth is usually self-limited. A few, mostly on the face, have taken on malignant characteristics and required drastic steps. If recognized for what they really are, the histologic report need not cause alarm; but it calls for circumspect waiting for two to three months or so, to permit the usual natural involution and disappearance of the lesion to take place, leaving some atrophy or scarring. Multiple keratoacanthomas may be present and even numerous; or one or two may come and go for a long time. Despite the admonition not to be too hasty about removing these growths, this is no license for complete disregard, but calls for continued observation. Where the expected involution fails to take place, of course, one should and must use surgery or radiation.

We are becoming increasingly aware of the many and subtle ways the skin reflects disorders of the corpus general, sometimes by the barest perceptible changes, and other times by recognizable overt manifestations. Some of these alterations may be in characteristic patterns that habitually accompany and reveal certain specific visceral, metabolic and pathologic entities. Besides the innumerable old ones, such as the moist steaming mien of hyperthyroidism and the equally cold, harsh, dry appearance of hypothyroidism, there are newer and a growing number of couplets to learn. They are:

1. The outer clue of pigmented macules, cysts, and fibromas, pointing to intestinal polyposis.
2. The rough, dirty, warty folds of acanthosis nigricans, associated with some cases of visceral cancer.
3. The baggy folds of pseudoxanthoma elasticum as part of a generalized disorder of elastic tissue, affecting especially the heart and great vessels and sometimes the gut.
4. Pyodermas, yeast infections, and some extraordinarily resistant superficial ringworm infections may be heralds of an undiscovered diabetes mellitus.
5. The chamois colored splotches, patches, and tumors of the xanthomas suggest hypercholesteremia, arterioscle-

rosis, future coronary thrombosis and cardiac infarction.

6. Xanthomas may betoken, too, widespread reticulohistiocytic disease with poor prognosis in infants and children.

Sun bathing is a current vogue, despite warnings about the deleterious effects of this practice on the skin of some people. All modern studies confirm the harmful effects of cumulative doses of ultraviolet light in "Nordic" types with blue eyes and fair skin, those with red hair and freckles, and others who for a variety of reasons are peculiarly sensitive to sunlight. Aside from the immediate and sometimes serious effects in subjects with conditions such as lupus erythematosus, pellagra, and the porphyrias, the long-term results are often senile elastosis, the so-called farmer's and sailor's skin, senile keratoses, lentigines, and epitheliomas. Their incidence is greater where sunlight is more intense and summers are longer. Thus, Texans suffer far more commonly from skin cancer than those living in Northern states.

Modern drugs are perhaps the commonest cause of light sensitivity. A few of the many that may evoke this are the phenothiazines, chlorthiazides, sulfonyl-urea derivatives, griseofulvin, and demethylchlortetracycline. Lastly, light may provoke urticaria, hydroa estivale, and so-called polymorphous light eruption—a variety of lesions, mostly on exposed parts, all of unknown underlying cause. Tetracycline and its derivatives, because they have come into such common use, need to be thought of as causal when puzzling over an obscure photosensitivity or nail discoloration, separation, or distortion. New evidence to explain the mystery of a prolonged and even permanently acquired dermatitis, which should have subsided on withdrawing a discovered irritant, may prove to be a photosensitivity or light allergy, accompanying or succeeding a contact dermatitis. Such photosensitivity need not be due to a systemic drug, but follow one used topically. If an apparent contact dermatitis does not clear after the incitant is gone, it behooves one to consider the possibility that a pho-

todermatitis may be present. And this may be due to ordinary light, just as well as ultraviolet rays. As a result, the dermatitis may be present throughout the year. The most important clue to arouse suspicion of a light sensitivity involves distribution of the dermatitis to the uncovered parts—head, neck, and hands. Since the victims are unable to escape the ubiquitous rays, they are doomed to suffer a prolonged or permanent dermatitis, since no method is presently known to desensitize these patients. Wearing gloves, broad brimmed hats, and other shields are protectives, as are chemical sunscreens, such as the red veterinary petrolatum and other preparations. For the dermatitis itself, standard soothing applications appropriate to the extent and degree of the dermatitis afford relief. One may use bland lotions, creams, and ointments alone or fortified with steroids.

Too often a patient presents with an eruption impossible to catalogue, but which has all the attributes of some systemic infection or disorder. For want of a more specific label, the rash is called a "toxic eruption." Naturally, when the cause of such an eruption is found, it is separated from the general group and given a distinct name. Such was the case when a group of acute urticarial or macular, papular, petechial, and vesicular eruptions was found associated, if not due to, Cocksackie A9 infections.¹² And further research is showing other viruses may also cause these non-specific appearing "toxic eruptions." Most of these rashes are generalized, though mild and ephemeral, too fleeting to bother with virological studies, except for academic purposes.

Many of the purpuric nodular and necrotic granulomatous lesions that seem to be of an allergic nature and that we see nowadays, either were not present formerly or we missed them. It is believed that the mass of present-day synthetic drugs accounts in large measure for these eruptions. Drugs, too, it is held, can induce autosensitization and manifest this clinically as periarteritis nodosa, Wegener's granuloma, as well as milder and less lethal forms.¹³

A large proportion of skin eruptions we routinely see are due to external irritants—contactants. We call the latter primary, when they eczematize almost everyone touching or working with them. Other agents in this group are called allergens. The latter produce a dermatitis only in a selected few on repeated contact. These cases of dermatitis venenata or contact dermatitis are relatively easy to diagnose if one thinks of them, notes distribution to uncovered parts, and by history taking. Modern technology is producing an ever-growing number of materials that act as primary irritants or as allergens. Epoxy resins in cloth and shoes, rubber and elastic in waistbands, chrome and nickel on metal parts, as of garters, dress shields at the axillas, soaps and cosmetics, hair rinses, dyes, and shampoos, are frequent, even common, causes of dermatitis.^{15, 16} The patch test is the easiest way to find the offending allergen. Though it seems simple to do, it requires some care and experience for proper interpretation of results.

Cheilitis exfoliativa, a chronic scaling of the lips, especially of the lower, may be due to irritants and allergens, such as food, drugs, and cosmetics. Sensitivity to light, especially in summer, should be thought of and treated by appropriate sun screening topical agents. Another cause recently demonstrated is infection with *Candida albicans*.¹⁷ This organism more commonly causes thrush and perleche, as well as superficial "raw beef" erosive sheets in skin folds, especially of actual or potential diabetics, and is usually and readily eradicated by antimonilials, such as nystatin, Fungizone, or one percent aqueous gentian violet paint.

Just as genetics has written new chapters in medicine, so too has it explained some aberrations of skin structure, function, and a few cutaneous syndromes. Therefore, there is hope that if recognized early something can be done for phenylketonuria, Wiskott-Aldrich syndrome, Hartnup's disease,¹⁸ and others. We need to know about their mode of inheritance, and potential for permeation of families. It may help future generations to recognize

and apprehend clinically unaffected relatives who may be carriers of seeds of these strange maladies.

While the corticosteroids were tried and used originally for the arthritides, nowhere have they revolutionized therapy of a field so completely and largely as that of dermatology. One uses them internally and topically, as well as intralesionally. And, as a refinement of their use in local applications, the improvement in their efficacy when applied under occlusive dressings has surpassed all expectations. Eczemas and psoriasis of even the most inveterate types often yield wholly or partially to this sophisticated form of topical application. With a little experience and care of its details, complications are rare and minor. One of these has come to light only recently. Especially under occlusive dressings, corticosteroids may produce skin striae or aggravate and enlarge existing ones.²⁸ The frustrations and discouragements of endless greasings for the chronic dermatitides are almost historical. Yet, we have overdone the steroids. We have learned to avoid using them systemically for psoriasis, even when it appears they may do some temporary good. Though the method is "clean" and convenient, and there may even be spectacular early improvement, we later face the dilemma of how to wean psoriatics from them without producing severe rebound effects.

Another advance in the treatment of psoriasis is the use of folic acid antagonists. This shows the rapid turnover of epidermal cells and has been of benefit in many cases. Both aminopterin and methotrexate have been used. They are usually reserved for severe and intractable cases; but one must use care and watch for signs of intolerance and complications, such as injury to blood forming organs, stomatitis, and other untoward effects. Pregnancy is a definite contraindication to their use. Old age may also be a contraindication.

The great hopes we had that penicillin would some day stamp out venereal disease are paralleled by what griseofulvin may do for tinea capitis or ringworm of the scalp. With this simple, specific, almost harmless

remedy, there is hope that early recognition of fungus infection of the scalp may halt epidemics and someday snuff out this endemic. While reliable figures are not at hand, it does appear that this perennial is lessening in incidence. And the antibiotic is of use too, where previously we felt almost helpless, for ringworm of fingernails, though the remedy must be persisted in for a number of months to achieve a cure. Toenail infections are more stubborn, but occasionally yield a surprisingly good result. For the ordinary and common infections of the feet, the standard agents are still indicated and almost always helpful. The exception is infection with *T. rubrum* which sometimes yields to griseofulvin. The efficient use of this antibiotic presupposes an accurate diagnosis and knowing after culture what organism is present. Thus, *T. rubrum* infection, which ordinarily does not respond to other treatment, will often give way to griseofulvin. Griseofulvin in the finer crystalline forms is effective in smaller doses, and when administered with a fatty meal more easily absorbed. There is still no unanimity of opinion regarding the optimum dosage forms. While many use one gram of the antibiotic daily until proof of cure, a few others prefer to administer as much as three grams as a single dose for tinea capitis and repeat the dose in the few patients where necessary.²²

But griseofulvin is ineffective for monilial infections, such as thrush, perleche, paronychias, and intertriginous infections. These have always been with us, but the broad-spectrum antibiotics multiplied their incidence. Nystatin and amphotericin B are specific remedies for these yeast infections.²³ And for most of the deep fungus infections, such as blastomycosis, histoplasmosis, and coccidioidomycosis, amphotericin, too, is the most effective drug. In a few instances, amphotericin B has been curative when given by mouth. When given intravenously, as it usually is, it is toxic to the kidneys. Renal damage is the limiting factor in its administration, and one must be alert to the possible development and presence of this complication.

Acne vulgaris, the almost universal ac-

companiment of youth and sometimes persisting beyond, is still being treated by some practitioners with x-rays; but this physical modality is not nearly as popular for that purpose as it once was. Topical agents, such as combinations of sulphur, salicylic acid, and resorcin, are still much used, as are numerous drying and peeling preparations. The latter, as pastes, ointments, lotions, and powders, are sold over the counter and prescribed; and they are easily accessible as elegant formulations, made available by ethical and reliable pharmaceutical firms. For this rich market there is great competition with much ballyhoo and extravagant claims so one must use care and discrimination to fit the prescribed product to indication. The broad-spectrum antibiotics, especially tetracycline, have come to be, however, the most reliable single form of acne treatment. Initially, one may use 750 to 1,000 mg a day for two or three weeks, when, as usually happens, improvement permits tapering off this dosage to a continuation one of 250 mg. Of course, topical, dietetic, and hygienic measures are still used in conjunction, and for such extended periods as cases require. With some study of the patient's individual pattern of flares, such as premenstrually, one can anticipate and forestall recurrences by doubling the dose of antibiotic beforehand or readministration after temporary or interval discontinuation. For cystic, deep and scarring lesions, some advocate the local injection of corticosteroids, and reports are that such therapy is more efficacious than anything else for this destructive form of acne. Antibiotics, though, should be given simultaneously, as well as all other remedies that are ordinarily useful. For the destructive aftermaths of these deeper lesions, planing or superficial avulsion of the skin by a rapidly rotating wire brush can have salutary effects. Candidates for this operation must be carefully chosen. It is important to consider the type of scarring which may be benefitted and the candidate's emotional makeup. This will avoid disappointment and unpleasantness.

Intensive and involved studies with the light and electron microscopes are step by

step piecing together the train of events leading up to the formation of melanin. Melanocytes, the dendritic cells of neural crest origin, the cells that elaborate this pigment, make it at elementary minuscules known as melanosomes. The final product within the extended arms of these cells—that is, the slender dendritic processes—are nipped off at their tips; and these pinched off particles are spoon fed to and become incorporated within the body of the basal epidermal cells. Topical applications of certain reducing agents, such as hydroquinone, can block pigment formation by inhibiting the oxidative action of tyrosinase. On the other hand, some substances, such as psoralens, increase the response of the skin to ultraviolet light and stimulate pigment production.²⁴ The discovery of the endocrine products influencing pigmentation and their role in this complex process is largely a triumph of American dermatological research. The pituitary melanocyte stimulating hormone and the deterring hormone, melatonin, from the pineal, together govern the rapidity, degree, and intensity of pigmentation—the one augmenting, the other checking. Other endocrine products, such as from the adrenals, are of secondary importance.

Can corticosteroids applied to the skin surface be absorbed in sufficient quantity to produce adrenal suppression or other side effects. It appears reasonably safe to treat fifty percent of the skin surface, even under occlusive dressings, as judged by determinations of the 17-ketosteroids and 17-hydroxycorticosteroids. However, steroids, especially the fluorinated ones, on eighty percent or more of the surface and under plastic film definitely suppress the adrenals when the epidermal barrier is broken or impaired by injury or disease. Withdrawal of the medicament quickly and easily reverses this systemic action. But since it is seldom that more than half the skin surface would be treated with steroids and occlusive dressings, we may say with assurance that corticosteroids applied to the skin are practically free of untoward systemic effects.²⁵

Steroid applications, especially when re-

inforced by occlusive dressings, saturate the horny layer and remain there as a reservoir. With no further additions to the original medication, evidence of the presence of the drug may be elicited for as long as fifteen days after the start of the experiment by merely reapplying a plastic film. Stripping the corneal layer from the skin abolishes this reservoir, as shown by indirect physiological demonstrations, though not by direct quantitative chemical determinations of the drugs themselves.²⁶

Of the many methods described and proposed for predicting or demonstrating allergy or hypersensitivity to penicillin, a new one hopefully appears to be sufficiently reliable and accurate to be of help. This employs a penicilloyl-polylysine, a polylysine conjugate of the penicillinic acid derived from penicillin. It is used as an intradermal test. The number of false positive and negative results is fewer than with other methods thus far described.²⁷

Clinicians often find it difficult to differentiate several viral infections of the skin and mucosa from each other and disorders that simulate them. Some of these are recurrent herpes simplex, aphthous stomatitis and herpes zoster, variola and varicella, warts and molluscum contagiosum. At times, they defy clinical differentiation. Isolation of the virus, animal inoculation, and the rise in serum herpes simplex antibodies, are available as a means of diagnosis, but these methods are cumbersome and not widely available. Hopefully, Coon's fluorescent antibody technique promises to become increasingly useful as a rapid screening and routine confirmatory serological procedure not only here but also for the diagnosis of syphilis. The same technique is being used as a test for antinuclear serum activity in the diagnosis of some of the autoimmune diseases such as lupus erythematosus. The list of adaptations for this relatively simple process is growing and includes visualization and identification of bacterial, viral, protozoan, helminthic, fungal, and animal tissue antigens. It may be used for locating antibody in tissues, and this has helped in the elucidation of certain disease processes in the skin,

to show the parts that are involved initially and secondarily. In like manner, serum antibody may be characterized. For the fungus infections of the skin, the serum antibody technique is more useful for the deep and serious mycoses, such as blastomycosis, sporotrichosis, histoplasmosis, and coccidioidomycosis than for the superficial ringworm and monilial infections of thrush and intertrigo. It is less useful for tinea versicolor and erythrasma (the pathogenesis of the latter is newly described as bacterial and not fungal, as was hitherto thought). The peculiar characteristic fluorescent properties of biological materials may be utilized by themselves or together with fluorescent drugs such as tetracycline activated by ultraviolet light in order to discover and delineate malignant tissue.¹ As a result, reasonably successful attempts have been made to demonstrate squamous cell cancer in the skin and to differentiate and distinguish some of the so-called precancerous formations on and in the skin, such as the solar and senile keratoses, from actual epitheliomas, and to trace the evolution of these early benign forms to the final malignant ones.

Many more problems involving the study of the skin, both in the clinic and laboratory, are presently in the "drawing board" stage. Because of the reciprocal relationship of the skin and the entire corpus, and accessibility of the integument for direct and microscopic observation of structure, chemical make-up, their variation and change, as well as pharmacodynamic responses, all of medicine can benefit from dermatologic research, and such study should attract the attention of biologists, the general practitioner, and specialists. Further illumination of the surface promises to banish more of the dark within and bring us closer toward an understanding that partitioning people into compartments and spheres, while convenient, is false and misleading.

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THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

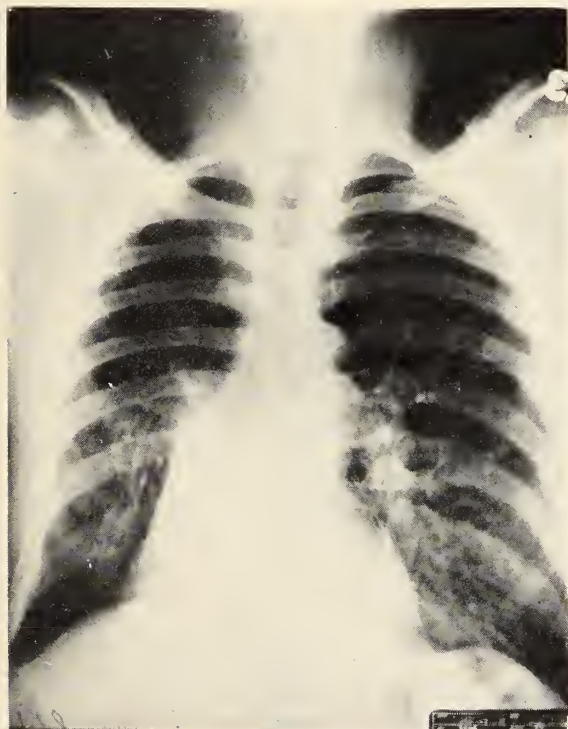


Fig. 1

A 31-year-old Negro male entered the hospital with complaints of bouts of fever associated with chest pain and coughing. He had been asymptomatic until the age of 25, and he had been hospitalized three times since then.

Physical findings revealed a slightly contracted right hemithorax with normal interspace. Dullness to percussion was noted at the right base. Pulmonary function studies revealed a vital capacity of 80% of normal. Sputum examinations were normal.

What is your diagnosis?

1. Atelectasis of the right lower lobe
2. Basilar TBc
3. Unilateral pulmonary hypoplasia
4. Aspirated foreign body

(continued on next page)

THE VIEW BOX---DIAGNOSIS AND DISCUSSION

(continued from preceding page)



Fig. 2

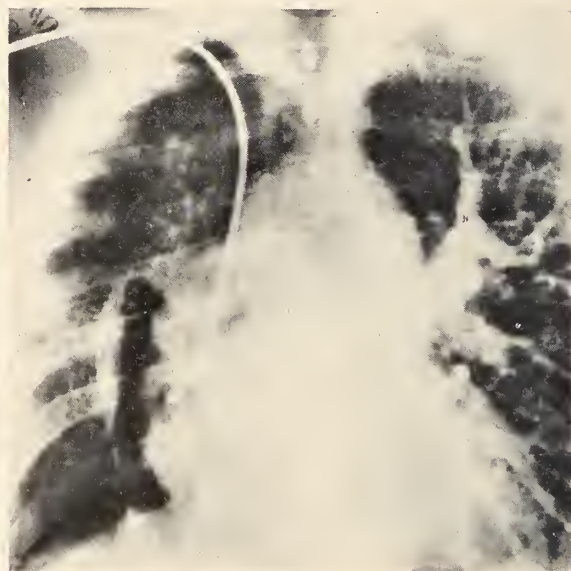


Fig. 3

Diagnosis:
Unilateral pulmonary hypoplasia.

In the PA chest (Fig. 1) there is a shift of the mediastinum to the right. The right pulmonary artery and its branches are extremely sparse. There is herniation of the left lung across the midline seen lateral to the right heart border. The right hemidiaphragm is slightly elevated. The left lung is emphysematous.

A bronchogram (Fig. 2) revealed the right main stem branches to be visualized with rudimentary branches noted. A venous angiogram through a catheter in the right atrium (Fig. 3) visualized a normal left pulmonary artery and only a bud of a right pulmonary artery. A retrograde thoracic angiogram revealed bronchial circulation which supplied the peripheral lung tissue. At surgery, a right pneumonectomy was performed and confirmed the radiological findings.

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EDITORIALS

THE RECOGNITION OF NONDISEASE

Nondisease is a new clinical entity that should be added to the diagnostic acumen of every consultant. It was proposed recently by Dr. Clifton K. Meador,¹ a Markle Scholar in Academic Medicine at the University of Alabama College of Medicine. Nondisease exists, according to Dr. Meador, when a specific entity is suspected but not found. The key words are "suspected" and "not found." The patient has symptoms or findings that lead the physician to suspect a certain condition but nondisease is (found) considered when the diagnostic and laboratory tests fail to (demonstrate) prove the existence of the disease. He stresses the point that these individuals are not just healthy; they had specific nondisease.

One of his examples was a slightly obese middle aged woman who was referred with a diagnosis of Cushing's disease. She had a moon shaped face, muddy complexion and prominent hair on the upper lip. Cushing's disease was excluded by the appropriate laboratory tests, and in fact no disease was found. Diagnosis: Non-Cushing's disease.

The most common of all nondiseases are classified as upper-lower-limit syndromes.

These are the men and women with borderline laboratory tests. In nonanemia the hemoglobin is 12.5 gm/100 ml and in nonhypothyroidism the PBI is 4.1 microgram/100 ml. A blood pressure of 150/80 is found in hypertension. The over interpretation of an X-ray in which a filling defect was noted on air-contrast barium enema study led to the diagnosis of polyp. It was not found at colectomy and the diagnosis was changed to a colonic nonpolyps. The most entrancing diagnosis was nonmitral insufficiency syndrome in a person with grade I (special) apical systolic murmur. The original diagnosis, mitral insufficiency, was disproven at a later date; the individual received this fancy diagnosis when it was obvious that the murmur was functional in nature.

His final observation brings out the ultimate value of the science of nondisease. "Treatment is always easy if the diagnosis is correct and nondisease clearly established. Stated simply, the treatment for nondisease is never the treatment for the corresponding disease entity."

T. R. Van Dellen, M.D.

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DO YOU SNEEZE PROPERLY?

Between the universal incidence of nasal allergy and the ubiquitous head cold, we are a world of sneezers. Less frequent stimulators are foreign bodies within the nasal interior, anatomical irregularities therein, and the not infrequent response to sunlight, emotion and sexual excitation.

Gone—or almost gone—are the days of

the snuff user. These addicts started the habit as a status symbol, or under the delusion that a sneeze or two was "good for the soul." In fact, the slight depression on the outer aspect of the thumb at its base was known as the "anatomical snuff box." A pinch of the stuff, placed in this

(continued on next page)

hollow and in-sniffed vigorously, was accepted form and indicated high breeding and gentility.

Now one would think that so elementary a reflex as sneezing would come naturally and harmlessly. Quite the opposite is the clinical truth. A considerable number of sneezers injure their nose, sinuses or middle ears by performing this simple act incorrectly.

For example, there are the grim-visaged, lip-locked individuals who direct the exiting force of the sneeze completely through the nose with shattering effect on the nasal membranes and the air pressure within the middle ear. Physicians see many cases of nosebleeds which are initiated by this type of sneeze. Less often treated are middle ear disturbances—pain, stuffiness, ringing, impaired hearing—consequent to this improper method of sneezing.

Again, there are the 'polite' sneezers who smother the sneeze or, worse still, have trained themselves to abort it. Either technique creates a menacing pressure within the head. Besides provoking a nosebleed or ear discomfort, these over-considerate individuals may infect their sinuses or cause immense harm, at times,

as witnessed by the occasional 'stroke' in senior citizens, resulting from the momentary rise of blood pressure which the smothered or aborted sneeze engenders.

Approaching but not quite attaining the proper performance is the "fire-alarm" sneezer who scares the daylights out of all living things within a radius of fifty yards by a blast which combines the nasal eruption method with an ear-splitting vocal accompaniment. These individuals usually turn misanthropic, a maladjustment resulting from the loss of friends and family in sheer self-defense.

We come now to the proper or safe way to sneeze. It is simplicity itself. All one need do is to keep the mouth open and permit the force of the sneeze to be expended orally. Obviously, the spray effect is not likely to increase one's popularity or win friends. Cupping the hands at the mouth is the answer. Those who have the time to reach for their handkerchiefs or tissues can place them between their mouths and social oblivion. The writer has also hurriedly used his hat when an unexpected sneeze developed in a theatre. In all events and at all costs, let that sneeze come out orally and live happily ever after.

David Mezz, M.D.

Health Department announcement

RADIATION HAZARDS

Copies of "Rules and Regulations for Protection Against Radiation Hazards," as amended in September, 1964, are available from Dr. Franklin D. Yoder, Director of the Department of Public Health, State Office Building, Springfield. The booklet contains all the information that users of ionizing radiation need to comply with the Illinois Radiation Protection Act.

SPECIAL REPORT OF FINANCE COMMITTEE

TO THE BOARD OF TRUSTEES

MAY 16, 1965

INTRODUCTION

THE Finance Committee of the State Medical Society submitted to the Board of Trustees a special report on the financial needs of the Society. The report of the Finance Committee was approved by the Board of Trustees, and was distributed to the House of Delegates at its first session on Sunday, May 16, 1965. Appropriately, the report was referred to the Reference Committee on Administrative Services for consideration. On Wednesday, May 19, 1965, the Reference Committee reported as follows:

"The recommendation of a dues increase as presented by the Finance Committee was basically an increase of \$17 per year in dues, with a voluntary contribution of \$15 per year to IMPAC-AMPAC. The Committee heard several testify that the AMA-ERF \$20 allotment should be eliminated. The Committee received assurances from the Finance Committee that our reserves have been depleted to a dangerously low level (\$129,000) in comparison to the annual budget. These must be built up to a safer level. Our Committee as a whole has considered many of the happenings of the past several years, and we feel that our Society will be called upon to speak for us at many different levels of the medico-economic strata. There will not be time to have special meetings and special assessments. Furthermore, we as a Society have to be thinking ahead and implement our thinking in order to avoid haste. This Committee feels that the following dues struc-

ture will meet our goals for the coming five years."

The Reference Committee then recommended that the dues should be \$95 per year. The General Fund allocation should be raised from \$58 to \$70; the Benevolence Fund allocation be raised from \$2 to \$7; the AMA-ERF allocation be reduced from \$20 to \$10; that \$8 be assigned to the permanent reserve fund; and that a voluntary contribution of \$25 be included on the dues statement for transfer to IMPAC-AMPAC, if paid by the individual member.

There was lengthy discussion by the members of the House of Delegates on the recommendations of the Reference Committee, especially on that portion regarding the AMA-ERF. By appropriate motion, the report was later amended to make the annual contribution to the AMA-ERF \$20 as it has been for the past 12 years.

Therefore, according to the final action of the House of Delegates, dues for 1966 will be \$105 in addition to a \$25 voluntary contribution to IMPAC-AMPAC included on the dues statement.

The following 13 pages of this issue of the IMJ contain the special financial report presented to the House of Delegates which the Board of Trustees has asked to have published for the information of all members. Questions concerning the report may be directed to the officers of the Society or to the Executive Administrator.

Jacob E. Reisch, M.D.
Secretary-Treasurer

I. GENERAL FUND

Budget for 1964 and Other Funds

For the budget year 1964 the Finance Committee recommended the adoption of a budget in which expenditures exceeded anticipated income. The preceding four years, 1960 through 1963, had enabled the Society to increase reserves from \$160,000 to almost \$200,000. But just as we save for future needs and emergencies in our personal lives it was felt justified to enter 1964 with an anticipated deficit for the reason that reserves had been set aside in the preceding three years to be called upon if and when needed.

The reason for expenditures exceeding income in 1964 was the long delayed implementation of an important public affairs program. This was budgeted and carried out with the full approval of the Board of Trustees and the House of Delegates. The final amount of money removed from the reserves and contained in the audit for 1964 was \$31,339. This reduced our general fund reserves at the beginning of 1965 to \$173,105. Attached to this report as Appendix #1 is a record of how these reserves were secured over past years.

Benevolence Reserves

In addition to general fund reserves, the Society has additional funds which are presently committed to specific activities. As reported in the 1964 year end audit, the Benevolence Fund reserve is \$151,848. This fund, under our Bylaws, is to be expended only for the relief of our members who are under financial hardship, and for the relief of widows and children. It is not the desire of the Finance Committee to use this fund for other purposes. As a matter of fact, it is the intent of the Finance Committee to increase the reserves of this fund to a much higher level.

Loan Fund Reserves

The special fund established for educational loans in 1948 remains in existence in cooperation with the Illinois Agricultural Association. As reported in the 1964 audit the balance in this fund is \$100,896. Although this money could be called upon, and the program discontinued, the Finance Committee believes that this project is an important factor in providing physicians to the rural communities of Illinois. It is, therefore, not the intent of the Finance Committee to recommend any change in this area of activity.

AMA-ERF Fund

Each year the Society allocates \$20 per member to the medical school of each regular dues paying member's choice. Since the beginning of this project, the physicians of Illinois have given an average of \$185,000 annually to the medical schools of this state and nation. The need of our medical schools for funds of this nature has been annually reported to our House of Delegates, and has been

fully explored in meetings with the Deans of Illinois Medical Schools during the past two years. It is, therefore, the intent of the Finance Committee to continue to recommend the allocation of \$20 per member within the dues structure of the Society.

Special Retirement Fund

During 1964 the Finance Committee authorized the Executive Administrator to establish a special retirement reserve for two long-term employees who would not be completely provided for under the current retirement program. This is a self-insurance program by the Society and \$20,000 has been authorized to be taken from the reserves for this purpose. Additional allocations will be provided for in each year's budget in the amount of approximately \$5,500 until these employees are actually retired. Although this fund of money may be used at any time by the Society, it would not be in the interest of the Society, or in the interest of its employees to use this money for current activities.

Audit for 1964 and IRS Clearance on 1963

Enclosed with the reports of this Annual Meeting is a copy of the audit for 1964 which gives complete data on the funds described previously in this report.

It should also be of interest that representatives of the Internal Revenue Service reviewed ISMS records for the year 1963. On March 4, 1965 we received notification that the Society was tax exempt for the year 1963.

II. 1965 BUDGET

In light of the financial resources of the Society, the Finance Committee began the preparation of the 1965 budget with the full intention of remaining within the income. After many hours of deliberation and careful screening of anticipated activities we presented a budget to the Board of Trustees in which anticipated expenditures exceeded income by \$28,200. The cover sheet for the 1965 budget adopted by the Board of Trustees in January is attached as Appendix #2. This shows the anticipated deficit of \$28,200 which was reduced from a potential \$60,000 deficit when the first draft of the budget was prepared with all requests for allocations included. For purposes of comparison the budget for 1964 is also shown on Appendix #2. Although there were areas which may have been further reduced by the Finance Committee, we finally concluded that any decrease in member services would only reflect poorly upon the Society, and that the House of Delegates should be presented a report of this nature so that the representatives of the House can make the final decision as to where the decrease in services should be made, if any. Also, whether a decrease in service should be made at this time as compared with a possible dues increase to provide for continued growth in the future.

Voluntary Contribution

It was particularly encouraging to the Committee when the 1964 House of Delegates approved the addition of a \$20 voluntary contribution to the dues statement for 1965. You should recall that this action was anticipated to relieve the general fund of any further allocation to the Benevolence Fund over and above the \$2 normally assigned from each member's annual dues. The income anticipated for Public Affairs was to be added to the general fund, and thus relieve the major allocation made in 1964 for this purpose. The contributions made to IMPAC were to assist that committee in accomplishing its purpose and establish a fund for their important functions especially aimed at the congressional elections in 1966.

The results of the 1965 voluntary contributions at the time of preparing this report (April 15, 1965) with dues paid by 6,212 members, and as assigned to the various funds are as follows:

	Actual	Anticipated	Maximum Potential
Benevolence Fund	\$18,485	\$25,000	\$46,000
Public Affairs	\$18,485	\$25,000	\$46,000
IMPAC	\$36,970	\$50,000	\$92,000
Total	\$73,940	\$100,000	\$184,000

It is disappointing to the Finance Committee that more members did not voluntarily contribute to the Society activities as set forth in the Substitute Resolution adopted at the 1964 Annual Convention. Be that as it may, however, the Finance Committee will continue to exert its influence on committee chairmen to reduce expenditures so that the year 1965 will not find us reducing the general reserves any more than absolutely necessary.

Eldercare Informational Campaign

On February 7, 1965, at the special meeting of the House of Delegates, the Finance Committee was given the responsibility of determining the amount needed to carry out the Eldercare Informational Campaign requested by the AMA. A special budget was prepared for this purpose and is attached as Appendix #3 with a maximum expenditure of \$252,000 up to June 1, 1965. Potentially there may be some small portion of this money unexpended by the time of the meeting of the House of Delegates. However, the 1965 budget as revised and including the \$25 supplementary dues income and Informational Campaign expenditures is attached as Appendix #4. Although the year end shows a potential \$1,300 excess of income over expenditures, it must be remembered that \$25,000 was allocated from the reserves by the Board of Trustees to match the AMA contribution. An additional allocation of \$20,000 has been authorized for the special retirement fund which will be removed from the reserves. Therefore, the reserves in the general fund will be reduced by ap-

proximately \$43,700 in 1965, and a remaining balance at the year end will approximate \$129,405.

Summary

In the funds of the Society at the present time we have:

General Fund	\$173,105
Benevolence Fund	\$151,848
Loan Fund	\$100,896
AMA-ERF	\$185,000

III. PAST FINANCIAL NEEDS & COMPARISONS

The basic needs of committees, officers and staff were well met by available income in 1960 through 1963. As recorded the reserves of the Society were increased by over \$40,000 during these years. However, in 1964, with the increase in Society programs, additional funds had to be employed. These, combined with other circumstances affecting the finances of the Society, resulted in the 1964 deficit which was financed from the reserves in the amount of \$31,339, and the anticipated deficit for 1965.

Primary circumstances which led to the 1964 deficit, and the 1965 anticipated deficit, are as follows:

1. A continued loss in advertising income for the Journal of approximately \$60,000 per year since 1961.
2. A request from membership for a Public Affairs program which required approximately \$35,000 for the year 1964, and is budgeted for \$25,000 in 1965.
3. Substantial support for the political education program of the Illinois Medical Political Action Committee in 1964.
4. Establishment of Special Retirement Fund for two employees effective in 1965.
5. Increase in cost of normal operation because of increase in cost of all services of 2% each year, especially in postage rates, purchase of supplies, etc. Attached as Appendix #5 is a table of relative changes in consumer price index and selected components.
6. Annual increases in rental for Chicago and Springfield offices built into leases signed in 1963 and 1964 for a period of 10 and 5 years respectively.
7. Increase in cost of legal fees and employment of General Legal Counsel whose duties were formerly carried out by Special Legal Counsel.
8. Services to organizations such as the Woman's Auxiliary, the Illinois Association of the Professions, the Illinois Medical Assistants Association and the Educational & Scientific Foundation.

9. Increase in requests from almost all committees due to interest as well as problems to be solved as assigned by the House of Delegates and the Board of Trustees.
10. Allocations for the special project on the development of the Museum in Springfield and the preparation of exhibit designs; also to make contacts to raise \$85,000.
11. Increase in allocations to Health Careers Council, the U. S. Chamber of Commerce, the Illinois Society for Medical Research, etc.
12. Increase in insurance rates and premiums covering officers, committee members, staff, as well as office equipment.
13. Increase in levels of staff salaries on a merit basis.

It is difficult to provide exact figures on the cost of each of the preceding items during the past two years except in those specific areas already mentioned. It is even more difficult to express these costs in exact dollar amounts when we consider some of the items which have increased during the past four years. We refer specifically to the Consumer Price Index, for example, which has increased a total of 8% for all services. The item which has most seriously affected our income for four years is the reduction in Journal advertising revenue. Although present advertising income is higher than most state journals of comparable size, the Society during the past four years has had a total decrease in income of approximately \$200,000. Had this \$200,000 been available to publish the Journal there would have been no need to use dues dollars, it may have been used for increased committee activities, or deposited as reserves. Thus, our present financial status would have been considerably improved, and the deficit for 1964 and the anticipated deficit for 1965 would probably not exist. Had the need for funds during the past eighteen months not been so dire, and the consequences so important, these additional dollars would have carried the Society for at least several more years.

Comparison with Other State Medical Societies

Frequently we must compare ourselves with others in order to determine if there is anything unusual about our organization which may cause deficit budgets. One measurement of our costs and program was made available to us by the Finance Committee of the Pennsylvania Medical Society. Attached as Appendix #6 is a copy of a comparative financial statement of Pennsylvania, New York, California and Illinois. This compares the balance sheets of the general funds on the income and expenditures for 1963 and the budgets for 1964.

It is most difficult for any one not completely familiar with each state's budget to ascertain ex-

actly the amount of money and staff personnel assigned to the activities covered in the comparative statement. Generally speaking, however, it would appear that Illinois is spending its major income in much the same ratio as the other three larger state medical societies. The Pennsylvania report ends with the statement that "It is believed that the income of the Pennsylvania Society is wisely spent to achieve the desired results in our various programs and compares favorably with the programs of other medical societies studied."

It is your Finance Committee's feeling that the Pennsylvania statement is equally applicable to Illinois at the time of the study. We have asked our Executive Administrator to periodically study the financial statements of other state medical societies, and if necessary, call a meeting with their business managers to agree on the format to be covered so that continuous information of this nature may be made available to us.

Other Association Studies

There are many ways in which organizations can be compared. The American Society of Association Executives in cooperation with the accounting firm of Ernst & Ernst in 1957 conducted an Operating Ratio Report for all types of associations. The comparative page of that report which presents 40 associations with income of \$500,000 per year, or over, is attached as Appendix #7. A similar page has been completed for ISMS and is attached as Appendix #8.

Increase in Salary Levels

According to a report from the Bureau of Labor Statistics in November, 1964, salary levels rose from 2 to 5 per cent for most professional, administrative, technical, and clerical work levels during the year ending February-March, 1964. See Appendix #9.

Over the three-year period since February-March 1961 average salary levels rose from 7.7 to 11.7 per cent. The median per cent increase over the three-year period was 8.3 per cent for the clerical levels, 9.9 per cent for lower professional levels, and 10.4 per cent for the fully experienced levels. These figures are ample evidence that if the Society is to continue to attract and hold competent personnel, increases in salary levels must be built into our yearly budgets. Even with the increase in the 1965 budget over 1964, only \$10,500 was included as salary increases which is 3.9 per cent of the total salary budget for the year 1964.

Increase in Number of Employees

The 1965 report of the Secretary-Treasurer to the House of Delegates contains a report on the growth of the staff since 1960. In order that it may be readily available to the reader of this report, the appropriate section of that report is abstracted and attached as Appendix #10. It may

be noted that the number of employees continues to compare very favorably with the number of employees in other state medical societies even though this is two years later.

Comparison of State Dues Levels

In recent years the state and county medical societies have been called upon to develop increased services and as a result all have been placed in a position of raising dues to meet the needs. A survey conducted by the Medical & Chirurgical Faculty of Maryland as of February, 1964, is attached as Appendix #11. It should be noted that without the \$20 allocation to the AMA-ERF Illinois dues for general fund purposes (\$58.00) compare favorably to other state dues. Twenty-nine state medical societies reported dues of \$60 or more.

IV. FUTURE NEEDS

Control of present financial resources as well as anticipation of future needs is the responsibility of the Finance Committee. It is further our responsibility to measure as accurately as possible the immediate, as well as the long-range needs. It is with these responsibilities in mind that we have prepared this report for the Board of Trustees, and if accepted, for transmittal to the House of Delegates. The following recommendations are presented for your consideration:

Recommendation #1

That the Board of Trustees report to the House of Delegates that the financial resources of the State Society are at dangerous minimum, and immediate steps should be taken to alter the trend toward further depletion of the reserves.

Recommendation #2

That the Board of Trustees reiterate to the House of Delegates the proposal of the Finance Committee made at the Board's January 16-17, 1965 meeting that the 1965 budget should be accepted and approved even in view of the anticipated expenditures exceeding income in the amount of approximately \$28,200.

Recommendation #3

That in view of decreasing resources as represented by loss in Journal advertising revenue, approximately \$60,000 per year since 1960, there must be an effort on the part of members to make up these losses in terms of increased dues.

Recommendation #4

That in view of requests for increased budgets by committees, the continued upward trend in cost of living, and concomitant increases in staff services a realistic dues schedule should be established for present needs which approximate the 1965 budget as adopted by the Board of Trustees.

Recommendation #5

That in view of the percentage of member participation in the voluntary contribution of \$20 for 1965, the \$5 for the Benevolence Fund, and the \$5 for Public Affairs should be included in the regular dues. Also in order to provide for those who wish to contribute in the future it is recommended that a \$15 voluntary contribution should be included on annual dues statements and collected by the Illinois State Medical Society for transfer to IMPAC and AMPAC.

Recommendation #6

That in view of the need for additional increases in income to provide for continued program, as well as staff services, during the future years, dues beginning in 1966 be automatically increased in concert with the increase in cost of living as set forth by the U. S. Government for the year 1965. This principle should be continued each year thereafter until such time as the cost of living should remain static.

Recommendation #7

That in view of the need to establish reserves in the amount of not less than six months' operating budget that annual dues be increased an amount to be determined by the House of Delegates and be set aside each year until reserves equal that amount, and that these dues be discontinued at that time unless otherwise determined.

Recommendation #8

That if the Board of Trustees and the House of Delegates should accept the previous recommendations, the Finance Committee should present its recommended budget for the year 1967 at the annual meeting in 1966, and from henceforth shall follow a similar pattern, unless otherwise altered.

Recommendation #9

That the Executive Administrator and his staff be recognized as providing very adequate financial statements and internal controls for the expenditure of funds by this Society over the period of the last five years, and further, that the Board of Trustees expresses its confidence in the financial policies as established by the Finance Committee in the administration of the funds of the Society.

The preceding recommendations are general in nature. The Chairman and representatives of the Finance Committee will be present and prepared to discuss the specific aspects of our recommendations before the Reference Committee.

Respectfully submitted,

Carl Clark, M.D., *Chairman*
Philip G. Thomsen, M.D.
Ralph N. Redmond, M.D.
Jacob E. Reisch, M.D.

Appendix #1

ILLINOIS STATE MEDICAL SOCIETY ANALYSIS OF GENERAL FUND RESERVES JANUARY 1, 1965

Time Period of Reserve Development	
Prior to 5/17/20	\$ 13,240
5/17/20 to 4/30/30	44,351
4/30/30 to 4/30/40	8,724
4/30/40 to 4/30/50	27,029
4/30/50 to 12/31/60	61,198
12/31/60 to 12/31/64	18,563
	<u>\$173,105</u>

Less:

Allocation from reserves to 1965 AMA information program- matching funds	25,000
Allocation in 1965 to Special Retirement Fund	20,000
Net reserves	<u>\$128,105</u>

Appendix #2

ILLINOIS STATE MEDICAL SOCIETY GENERAL FUND 1964 AND 1965 BUDGET COMPARISON JANUARY 1, 1965

	Original 1964 Budget	Original 1965 Budget
Receipts:		
Membership dues	\$537,000	\$544,000
Illinois Medical Journal	77,500	80,000
Exhibit fees	14,000	15,000
Investment income	15,000	15,000
Sale of Public Relations aids	-0-	1,000
Staff services for others	8,500	5,000
Miscellaneous	3,000	3,000
Gain (loss) on invest. redempt	-0-	-0-
Retirement fund refunds	1,000	2,000
Voluntary contributions for Public Affairs (50% of members X \$5 estimated)		25,000
	<u>\$656,000</u>	<u>\$690,000</u>
Expenses:		
Board and Officers		
Meetings—	\$ 30,000	\$ 31,300
ISMS	24,000	24,700
AMA	26,000	29,000
Administration	73,850	72,500
Business Services	66,100	72,800
Public Relations	83,850	92,600
Legislation and Public Affairs	113,600	112,800
Springfield Regional Office	41,200	43,300

Economics and Insurance	29,000	30,300
Publications and Scientific Services	48,050	47,400
Illinois Medical Journal	102,000	101,300
Non-Departmental	51,100	60,200
	<u>\$688,750</u>	<u>\$718,200</u>
Deficiency of receipts over expenses	<u>\$ 32,750</u>	<u>\$ 28,200</u>

Appendix #3

ILLINOIS STATE MEDICAL SOCIETY SPECIAL ELDERCARE INFORMATION CAMPAIGN

1965 BUDGET (to June 1)

MEETINGS:

ISMS House of Delegates— February 7	\$ 1,500	
AMA House of Delegates— February 6/7	1,500	\$ 3,000

BUSINESS SERVICES:

Part-time clerical assistance	2,000	
Telephone/teletype/telegraph (incl. WATS line)	2,000	
Equipment rental and purchases	3,000	
Office and mail room supplies	3,000	
Printing and reproduction (our shop)	2,000	
Freight/delivery/UPS/postage	1,000	13,000

CITIZENS FOR ELDERCARE COMMITTEE:

Part-time staff coordinator	3,500	
Rental of office space	1,000	
Telephone service	1,000	
Special literature for distribution in quantity to the public—		
Printing	5,500	
Mailing—postage, UPS, etc.	2,500	13,500

PUBLIC RELATIONS:

Regular Campaign— Radio (downstate) Ten 90-sec. spots ea. week/28 stations/2-14 to 5-30	23,000	
Newspapers (statewide)— One 750-line ad every 2 weeks/105 papers/ 2-22 to 5-30	60,000	
**Outdoor Adv. (statewide) Billboards/43 Chicago, 100 Downstate/3-10 to 4-10	7,000	
**Promotion (McGuinn)— News releases, posters, buttons, Citizens Comm.	10,000	

**Committed as of 3/1/65

Ethnic Papers (Chicago)— 10 foreign language papers/2 ads each	3,000	
**Production Costs (for all of the above)	11,000	114,000
Special Campaign—Two Weeks (beg. about 3-15)— Radio (Chicago)— Three big stations/ 2 spots daily	12,000	
**Television (statewide)— 16 stations/125 spots per week/4 weeks	28,000	
Outdoor Adv. (statewide)— Billboards/43 Chicago/ 100 Downstate/4 weeks	7,000	
Radio (downstate)— Expand coverage/20 new stations/10 spots each week	4,500	51,500

LEGISLATION AND PUBLIC AFFAIRS:

Staff field work	\$ 3,000	
Eldercare speakers travel	750	
Opinion leaders meetings	1,250	
Orientation meetings/ briefings/coffees	1,500	
Illinois Congressional contact	2,500	
Speech writer	1,000	10,000

ECONOMICS AND INSURANCE:

Professional Speakers Bureau— Flat fees, travel, and honorarium paid to non- physician, professional speakers appearing before large groups of professionals, business leaders, etc.		12,000
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PUBLICATIONS:

Special P.A. Newsletter to opinion leaders— Printing, mailing and 1st class postage	30,000	
Consultant on copy/ production/art/etc.	3,000	
Special issue—IMJ	2,000	35,000
TOTAL		\$252,000

**Committed as of 3/1/65

Appendix #4

ILLINOIS STATE MEDICAL SOCIETY GENERAL FUND—1965 BUDGET REVISED FEBRUARY 7, 1965

RECEIPTS:

Membership dues— Regular @ \$58	\$544,000
Supplementary @ \$25	230,000
Voluntary @ \$20 (only \$5 for Gen'l Fund) (Estimate 50% payment by members)	25,000

Allocated from reserves towards AMA matching funds for Eldercare information campaign	25,000
Matching funds from AMA for information campaign	26,500
Illinois Medical Journal	80,000
Exhibit fees	15,000
Investment income	15,000
Staff services for others	5,000
Miscellaneous	3,000
Gain (loss) on invest. redempt	1,000
Retirement fund refunds	2,000
Total receipts	\$971,500

EXPENDITURES:

Board and Officers	31,300
Meetings— ISMS	24,700
AMA	29,000
Administration	72,500
Business Services	72,800
Public Relations	92,600
Legislation and Public Affairs	112,800
Springfield Regional Office	43,300
Economics and Insurance	30,300
Publications and Scientific Services	47,400
Illinois Medical Journal	101,300
Non-Departmental	60,200
Sub-total	\$718,200
Special Information Campaign	252,000
Total expenditures	\$970,200
1965 Budget Surplus	\$ 1,300

Appendix #5

ILLINOIS STATE MEDICAL SOCIETY TABLE OF RELATIVE CHANGES IN CONSUMER PRICE INDEX AND SELECTED COMPONENTS

1960-1964

(1957-59 = 100)

63-64

%

	1960	1961	1962	1963	1964	Change
CPI—All Items— U. S.	103.1	104.2	105.4	106.7	108.1	1.3
All Services	105.6	107.6	109.5	111.5	(113.7)*	2.0
Medical Services	109.1	113.1	116.8	120.3	(123.1)	2.3
Medical Care	108.1	111.3	114.2	117.0	(119.5)	2.1
Physicians' Fees	106.0	108.7	111.9	114.4	(117.2)	2.4
Hospital Rates	112.7	121.3	129.8	138.0	(147.1)	6.6

* () indicates preliminary figure

Appendix #6

SUPPLEMENTAL REPORT 3

Board of Trustees and Councilors
(Referred to Reference Committee on
Reports of Officers)

To the House of Delegates:

In August, William A. Limberger, M.D., Chairman of the Finance Committee, presented a comparative report to the Board of Trustees showing the financial status of four of the largest state medical societies. The Board was impressed with this report and requested that it be disseminated to the House of Delegates for its information. Before this could be done, however, permission had to be granted from the other state societies involved in the study. The state societies of California, Illinois, and New York have consented and approved the information contained therein as it relates to their organization. We, therefore, submit the following report to you for your information and enlightenment.

Report of the Finance Committee August 3, 1964

The Finance Committee has compared the Balance Sheets of the General Funds, the Summary of Income and Expenditures for 1963 and the budgets for 1964 of the Medical Societies of the States of California, Illinois and New York with similar statements of the Pennsylvania Medical Society.

The membership of the four Societies is approximately as follows:

California Medical Association	—	21,000
Illinois State Medical Society	—	11,000
Medical Society of New York	—	24,000
Pennsylvania Medical Society	—	12,000

Following is a condensed summary of the Statements of Income and Expenses of the four medical societies for 1963. It will be noted that a considerable amount is accredited to Miscellaneous Income for the Medical Society of New York. A breakdown of this would necessitate many additional items.

STATEMENT OF INCOME AND EXPENSES FOR 1963

	California	Illinois	New York	Pennsylvania
Income				
Membership Dues	\$1,391,256	\$537,618	\$1,059,505	\$539,395
Official Journal	210,669	79,875	264,185	80,228
Other Advertising	-----	-----	86,000	-----
Interest Earned	3,276	17,119	4,351	19,598
Income from Annual Meeting	39,405	14,475	55,935	26,130
Medical Directory Sales and Advertising	-----	-----	50,947	-----
Miscellaneous	9,147	10,449	44,296	5,767
TOTAL	\$1,653,753	\$659,536	\$1,565,219	\$671,118
Expenses				
Official Journal	\$ 231,350	\$102,130	\$ 415,867	\$108,513
Administration	672,440	310,337	621,113	306,557
Scientific, Educational and Communications	802,795	225,622	390,565	292,603
TOTAL	\$1,706,585	\$638,089	\$1,427,545	\$707,673
Balance for the Year	- 52,832	+ 21,447	+ 137,674	- 36,555

Included in the amount for administration are the following: AMA Sessions, Annual Session, Building Operation and Rent, Employees Benefits and Retirement Fund, Grant to Educational and Scientific Trust, Membership and Operating Services, Officers' Conference, Officers' Travel and Expense, Salaries, Secretary's Office and certain other items of a similar administrative nature. The relationship of expenses for administration in comparison with income is as follows:

	Number of Employees	Cost	Total Income	Percentage of Total Income
California	53	\$672,440	\$1,653,753	41%
Illinois	34	310,337	659,536	47%
New York	66	621,113	1,565,219	40%
Pennsylvania	41	306,557	671,118	45%

It will be noted that the percentage of Administration costs for Pennsylvania compares favorably with that of the other three State Societies.

An analysis of the cost of producing the Official Journals of the four societies is as follows:

	1963	Journal Income 1963	Anticipated Journal Income 1964
California	Loss \$ 20,681	\$210,669	\$240,000
Illinois	Loss 22,255	79,875	77,500
New York	Loss 150,682	264,185	263,000
Pennsylvania	Loss 28,285	80,228	90,600

California and Pennsylvania expect greater Journal revenue; Illinois and New York see no prospects of any more income. It is interesting to note

that all four State Medical Societies suffered a loss in producing their Official Journals.

The cost of meetings of the governing bodies (Trustees, Councilors, and Officers) of the four Medical Societies is as follows:

California	\$52,697	Cost of meeting and travel expenses
Illinois	26,443	Meeting expense, travel and per diem
New York	25,411	Cost of meeting and travel expenses
Pennsylvania	23,633	Cost of meeting, expense accounts and per diem

Another item that was analyzed was the cost of the American Medical Association meetings for the individual societies. The following shows the total costs and the cost per delegate and alternate delegate:

	Cost	Number of Delegates	Number of Alternate Delegates	Amount Per Individual
California	\$34,835	21	21	\$ 828
Illinois	28,191	11	11	1,281
New York	26,781	24	2	1,031
Pennsylvania	17,353	12	3	1,157

The amount per delegate should not be considered too seriously as there are overhead expenses for each society that are approximately the same regardless of the number of delegates and

alternate delegates; namely, rental of the hospitality suite and operation of the same. The \$28,191 spent by Illinois includes \$5,000, the cost of their luncheon for all of the delegates to the AMA.

Officers' Conferences are conducted by three of the four medical societies. The amount spent by each society for 1963 is as follows:

California	\$12,990
Illinois	11,675
New York	.....
Pennsylvania	12,981

The last item to be presented is the cost of the Annual Sessions for the four medical societies:

	Cost	Income	Net Result
California	\$50,768	\$39,405	\$ - 11,363
Illinois	25,016	14,475	- 10,541
New York	50,772	55,935	+ 5,163
Pennsylvania	41,649	26,130	- 15,519

It is almost impossible to compare the amounts spent by the medical societies for their educational, scientific, and other programs due to the great diversity of the programs in the individual medical societies. No attempt was made to compare the Medical Benevolence or Medical Defense Programs.

As a result of this study, it is believed that the income of the Pennsylvania Medical Society is wisely spent to achieve the desired results in our various programs and compares favorably with the programs of other medical societies studied.

Respectfully submitted,
Malcolm W. Miller, M.D., *Chairman*
Board of Trustees

Appendix #7

TOTAL 1957 EXPENSES OR DISBURSEMENTS: \$500,000 AND OVER

Number of Associations Included: 40

By Scope of Association: 39 National, No State or Regional, 1 Local

By Type of Association: 17 Manufacturing; No Wholesale; 5 Retailing; 1 Finance, Banking & Insurance; 9 Service Other Than Finance, Banking & Insurance; No Construction;

1 Transportation: 7 Professional; No Other Types of Industry

ACCT. NO.	ACCOUNT DESIGNATIONS	1957				
		DOLLAR TOTAL	NO. IN TOTAL	AVERAGE	HIGH	LOW
INCOME (OR RECEIPTS)						
1	Income from Membership Dues or Fees & Entrance & Initiation Fees	\$26,154,135	40	66.2%	112.8%	6.2%
2	Income from Special Assessments or Special Payments	3,381,364	14	8.5	80.0	0.8
3.1	Income from Sales of Supplies or Materials, Hand or Text Books & Similar Publications	2,428,639	29	6.1	42.6	0.1
3.2	Income from Magazine Subscriptions, Annuals & Advertising Space	4,927,997	16	12.5	77.1	0.8
4.1	Income from Meetings & Conventions	1,311,500	24	3.3	68.9	0.2
4.2	Income from Trade Shows & Exhibits	1,578,489	14	4.0	84.0	0.02
5	Income from Educational & Training Courses	496,857	10	1.2	13.4	0.2
6	Income from Service Charges	654,706	7	1.7	17.1	0.3
7	Interest & Income from Investments	429,161	33	1.1	3.4	0.1
8	Other Income	1,224,200	30	3.1	18.3	0.0002
10	TOTAL INCOME (OR RECEIPTS) — Accounts 1 through 8	\$42,587,048	40	107.7%	142.6%	92.8%
EXPENSES (OR DISBURSEMENTS)						
20	Total Salaries	\$14,660,171	40	37.1%	60.1%	7.8%
21.1	Traveling Expenses of All Employees	1,749,806	37	4.4	18.9	0.1
21.2	Traveling Expenses of Members of Board of Directors & Committees	921,205	26	2.3	15.5	0.1
22	Rent, Light, Maintenance & Repairs	1,498,826	40	3.8	7.8	0.6
23	Stationery, Office Supplies & Expenses	879,628	40	2.2	5.2	0.3
24	Telephone & Telegraph Expense	525,135	40	1.3	1.3	0.2
25	Postage, Express & Freight Expense	814,746	40	2.1	4.2	0.1
26	Dues, Contributions & Expenses therewith	361,086	36	0.9	4.8	0.04
27	Publications & Subscriptions	369,249	34	0.9	26.1	0.03
28	Insurance & Taxes	314,819	37	0.8	3.5	0.1
29.1	Expenses of Meetings & Conventions	1,456,926	36	3.7	30.1	0.4
29.2	Expenses of Trade Shows & Exhibits	627,268	16	1.6	29.0	0.1
30	Publications, Forms & Systems Printed by Outside Firms	5,159,782	37	13.1	42.0	0.1
31	Depreciation on Office Furniture, Fixtures & Equipment	137,739	10	0.4	2.1	0.04
32	Cost of Office Furniture, Fixtures & Equipment	218,500	26	0.6	2.2	0.1
33	Audit, Legal & Other Similar Professional Fees	867,787	39	2.2	9.5	0.1
34.1	Special Projects for which Payments Are Made to Outside Organizations or Individuals	1,559,666	30	3.9	26.8	0.1
34.2	Expenses of Public Relations Programs	1,827,949	28	4.6	71.0	0.2
34.3	Expenses in connection with Educational & Training Courses & Special Services	515,221	18	1.3	10.7	0.2
35	Expenses of Advertising Programs	1,441,168	14	3.7	26.2	0.4
36.1	Employee Benefit Plans such as Group Life & Hospitalization	107,419	26	0.3	1.3	0.02
36.2	Employee Retirement Plans	888,123	36	2.2	6.1	0.5
37	Other Expenses	2,624,304	36	6.6	56.2	0.1
40	TOTAL EXPENSES (OR DISBURSEMENTS) — Accounts 20 through 37	\$39,526,523	40	100.0%	100.0%	100.0%
50	EXCESS OF TOTAL INCOME OR TOTAL EXPENSES — Account 10 minus Account 40	\$ 3,060,525	40	7.7%	42.6%	7.2%*
NUMBER						
C	Number of Association Employees—Full	2,216	40	55	170	4
	Part-time	72	17	4	18	1
D	Number of Association Employees Covered by Pension Plan	950	37	26	122	4
E	Total Number of Members of All Classes as of December 31, 1957	308,820	40	7,721	62,276	17

*Indicates negative figure.

Appendix #8
FORM FOR INDIVIDUAL ASSOCIATION COMPARISONS
1964 ACTUAL

ACCOUNT NUMBER	ACCOUNT DESIGNATIONS	YOUR ASSOCIATION AVERAGE
	INCOME (OR RECEIPTS)	
1	Income from Membership Dues or Fees & Entrance & Initiation Fees	76.77
2	Income from Special Assessments or Special Payments	.....
3.1	Income from Sales of Supplies or Materials, Hand or Text Books & Similar Publications	.....
3.2	Income from Magazine Subscriptions, and Advertising Space	12.59
4.1	Income from Meetings and Conventions	2.29
4.2	Income from trade shows & exhibits	.....
5	Income from Educational & Training Courses	.....
6	Income from Service Charges	.....
7	Interest & Income from Investments	2.01
8	Other Income	1.91
10	TOTAL INCOME (OR RECEIPTS) — Accounts 1 through 8	95.57%
	EXPENSES (OR DISBURSEMENTS)	
20	Total Salaries	37.87
21.1	Traveling Expenses of all Employees	3.63
21.2	Traveling Expenses of Members of Board of Directors	4.88
22	Rent, Light, Maintenance & Repairs	4.97
23	Stationery, Office Supplies & Expenses	1.26
24	Telephone & Telegraph Expense	2.61
25	Postage, Express & Freight Expense	.91
26	Dues, Contributions & Expenses therewith	.51
27	Publications & Subscriptions	.....
28	Insurance & Taxes (Payroll)	1.64
29.1	Expenses of Meetings & Conventions	6.02
29.2	Expenses of Trade Shows & Exhibits	.....
30	Publications, Forms & Systems Printed by Outside Firms	.....
31	Depreciation on Office Furniture, Fixtures & Equipment	.....
32	Cost of Office Furniture, Fixtures & Equipment	.70
33	Audit, Legal & Other Similar Professional Fees	1.90
34.1	Special Projects for which Payments Are Made to Outside Organizations or Individuals	.....
34.2	Expenses of Public Relations Programs	6.02
34.3	Expenses in connection with Educational & Training Courses & Special Services	.....
35	Expenses of Advertising Programs	.....
36.1	Employee Benefit Plans such as Group Life & Hospital	.79
36.2	Employee Retirement Plans	3.09
37	Other Expenses including Committee Budgets	23.20
40	TOTAL EXPENSES (OR DISBURSEMENTS) — Accounts 20 through 37	100.00%
50	EXCESS OF TOTAL EXPENSE Account 10 minus Account 40	4.43%
C	Number of Association Employees — Full Part-time	29 7
D	Number of Association Employees covered by Pension Plan	20
E	Total Number of Members of all Classes as of 12/31/64	10,500

March 1, 1965

Bureau of Labor Statistics
219 South Dearborn Street
Chicago, Illinois 60604
Telephone: 828-7230

FIFTH NATIONAL SURVEY OF
PROFESSIONAL, ADMINISTRATIVE,
TECHNICAL, AND CLERICAL PAY,
FEBRUARY-MARCH 1964

During the year ending February-March 1964, salary levels rose from 2 to 5 percent for most of the professional, administrative, technical and clerical work levels studied, according to the fifth nationwide salary survey released today by the Department of Labor's Bureau of Labor Statistics. Among the larger occupational groups studied, increases in average salaries amounted to 2.9 percent for engineers, 2.8 percent for accountants, 3.3 percent for chemists, 3.6 percent for engineering technicians, and 2.9 percent for clerical employees.

Over the 3-year period since February-March 1961, average salary levels rose from 7.7 to 11.7 percent for the 12 occupational groups comprising all levels studied. The median percent increase over the 3-year period was 8.3 percent for a grouping representing primarily clerical levels, 9.9 percent for a grouping of lower professional and administrative levels, and 10.4 percent for the fully experienced levels.

The survey covered over a million employees in 75 selected occupation work levels—48 professional and administrative, 8 technical, and 19 clerical. The occupations and work levels were selected from the following fields: Accounting, legal office services management, personnel administration, engineering, chemistry, drafting, and clerical. The definitions used to classify employees by occupations and level of work appear in the report.

This annual BLS survey was designed, among other uses, to provide a basis for comparing Federal salaries with the general pay levels in private industry. The definitions used in the survey were graded by the U. S. Civil Service Commission in accordance with the standards established for each grade under the Classification Act. The equivalent Classification Act grade for each of the work levels surveyed is identified in an appendix to the report.

Salaries for engineers, the largest professional group studied, ranged from \$612 a month for college graduates in trainee positions to \$1,707 for those responsible for highly complex engineering

programs, the highest among eight levels studied. At level IV, representing fully experienced employees and the largest group in each profession, engineers average \$918 a month and chemists \$886.

Among five engineering technician levels defined for survey, intermediate levels III and IV, at which a majority of the technicians were classified, had average salaries of \$556 and \$626 respectively. Senior (fully experienced) draftsmen averaged \$585 a month.

Salaries of accountants ranged from \$520 for accountants I to \$964 for accountants V, the highest level studied. Auditors average \$486 at level I and \$857 a month at level IV, the highest level surveyed in that series. Level I of both accountants and auditors represented trainees with bachelor's degrees in accounting or the equivalent in education and experience combined. At level III, which was the largest group in such series, monthly salaries averaged \$659 for accountants and \$710 for auditors. Salaries for chief accountants also were surveyed.

Attorneys (with LL.B. degrees and bar membership) in trainee positions averaged \$604 a month; the highest average among seven levels of attorneys surveyed was \$2,024. The attorneys included in the study were those employed in legal departments of various manufacturing and non-manufacturing firms.

Directors of personnel and job analysts, each representing four levels of work, were studied in the personnel management field. Personnel directors with job functions as specified for the defined levels of responsibility, averaged \$805 for level I and \$1,376 for level IV.

Among the clerical levels surveyed, average salaries ranged from \$259 for file clerks I to \$496 for tabulating-machine operators III, who perform complete tabulating assignments by machine, including difficult wiring, without close supervision. Stenographers, who accounted for the largest clerical group, averaged \$356 for the general, and \$403 for the more experienced senior level.

Appendix #10

ABSTRACTS OF SECRETARY-TREASURER'S REPORT—1965 STAFF DEVELOPMENT 1960-1965

The Administrative Staff

It is now five years since the reorganization of the administrative staff of this Society. During this period of time many changes in the activities of the Society have taken place, existing programs expanded, new projects initiated, additional services provided, and better liaison developed with component societies and individual members.

That this has been accomplished is a matter of record; less well known is how it has been done and by whom. I am certain that the membership will be interested in the tabulation of Staff Organization as developed since January, 1960.

During the five-year period it has been customary, as a matter of fact, it has been necessary at times to make major shifts in assignments for employees. The numbers of employees listed after each Division as of January of each year do not necessarily reflect themselves in the total number of employees for each year.

The following statements regarding major staff additions throughout the five-year period will be helpful in understanding the tabulation.

As of January 1, 1960, there were 16 employees of the State Medical Society, 4 in Monmouth; 11 in Chicago; and 1 legislative representative in Springfield.

In May of 1960, a projected Chart of Staff Organization was authorized by the House of Delegates, and 28 full-time positions were included, and described in the report of the Executive Administrator.

In 1963, additions to the staff occurred when two employees were authorized by the Board of Trustees for the administration of the Educational and Scientific Foundation of the Illinois State Medical Society. The salaries of these employees have been virtually self-sustaining by means of grants to the Foundation for projects since that time. Also, a third person was added because a former full-time employee requested to be retained on a part-time basis, and the major portion of her full-time salary was then used to employ an additional full-time clerk-typist.

In 1964, a major realignment of the staff was made in order to create a Division of Economics

and Insurance. This in itself did not add any new employees. However, the institution of a Public Affairs Program, authorized by the Board of Trustees, increased staff by the employment of a Director of Public Affairs and a secretary under the Division of Legislation and Public Affairs.

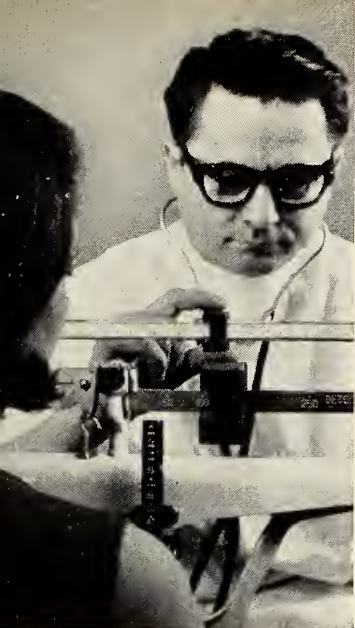
In 1965, one full-time staff member serving the Journal was changed to a part-time Assistant Editor. Also added to the Public Relations staff was the services of one part-time secretary, the major portion of whose salary is principally paid for by the Illinois Association of the Professions.

ABSTRACTS OF SECRETARY-TREASURER'S REPORT STAFF ORGANIZATION AS OF

	1/1/61	1/1/62	1/1/63	1/1/64	1/1/65
Adminis- tration	3	4	6	6	6
Business Services	7	8	5	6	6
Public Relations	4	4	5	5	6
Legislation & Public Affairs	3	3	5	6	6
Springfield Regional Office	4	4	3	3	3
Economics and Insurance	0	0	0	2	2
Publications & Scientific	4	2	2	2	2
Illinois Medical Journal	5	5	5	4	4
ISMS Foun- dation	0	0	2	1	1
Total number of em- ployees	<u>30</u>	<u>30</u>	<u>33</u>	<u>35</u>	<u>36</u>
Number of Full-time employees	26	27	28	30	29
Number of Part-time employees	4	3	5	3	7

STATE MEDICAL SOCIETIES DUES AND ASSESSMENTS

State Medical Societies	Current Dues	Assessments	1963 Increase Dues—Amount	1964 Planned Increase In Dues—Amount
Alabama	\$ 50.00		No	No
Alaska	75.00		No	No
Arizona	105.00		Yes \$20.00	No
Arkansas	45.00		No	No
California	75.00		No	No
Colorado	70.00		No	No
Connecticut	45.00		Yes 5.00	....
Delaware	80.00		Yes 25.00	No
District of Columbia	70.00		No	No
Florida	50.00		Yes 10.00	No
Georgia	40.00		No	No
Hawaii	100.00		Yes 40.00	No
Idaho	100.00		No	No
Illinois	80.00		No	No
Indiana	55.00	+ \$25 in 1965	Yes 5.00	No Raised in 1965
Iowa	90.00		No	Yes Not determined
Kansas	50.00		No	No
Kentucky	75.00		Yes 25.00	No
Louisiana	50.00			
Maine	55.00	\$ 25 AMA-ERF		
Maryland	50.00	10 Bldg. Fund		
Massachusetts	35.00		No	No
Michigan	80.00	10 AMA-ERF	Yes 10.00	No
Minnesota	75.00		Yes 20.00	No
Mississippi	95.00		No	No
Missouri	50.00		Yes 7.50	No
Montana	65.00		No	No
Nebraska	55.00		Yes 10.00	No
Nevada	120.00	100 Bldg. Fund	No	No
New Hampshire	75.00		Yes 15.00	....
New Jersey	45.00		No	No
New Mexico	90.00		No	No
New York	45.00		Yes 10.00	No
North Carolina	60.00		Yes 10.00	....
North Dakota	100.00		No	No
Ohio	35.00		Yes 5.00	To be raised \$10 in 1966
Oklahoma	57.00		No	Yes \$10.00
Oregon	60.00		Yes 10.00 (in 1962)	No
Pennsylvania	75.00		Yes 15.00	No
Puerto Rico	100.00		No	Yes 21.00
Rhode Island	60.00		No	No
South Carolina	35.00		No	No
South Dakota	100.00		No	No
Tennessee	40.00		No	No
Texas	45.00		No	Yes 10.00
Utah				
Vermont	65.00		No	No
Virginia	40.00		Yes 15.00	No
Washington	60.00		No	No
West Virginia	50.00		Yes 12.00
Wisconsin	90.00		No	No
Wyoming	50.00		No	No



YOUR SUPERVISION



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OBEDRIN MENU PLAN

A WEIGHT CONTROL PROGRAM YOUR PATIENTS WILL STAY WITH... AND FEEL BETTER

- 1. YOUR SUPERVISION** orients the patient to the need, goals and course of weight reduction . . . regular checkups confirm progress and support patient's morale.
- 2. OBEDRIN-LA:** 1 tablet daily "trickle releases" medication for all-day appetite suppression.
- 3. OBEDRIN MENU PLAN:** . . . aids weight reduction . . . provides a plan for necessary nutritional support and helps patients establish better eating habits.

Write today for free starter doses and Menu Plans, or contact your Massengill Representative.

DOSAGE is 1 tablet daily, usually at 10 a.m.

SUPPLIED in bottles of 50 and 250 tablets, on prescription only.

CAUTION: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage. Use with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution during pregnancy, especially in the first trimester.

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Obedrin[®]-LA^{*}

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Each tablet contains Methamphetamine HCl*, 12.5 mg.; Pentobarbital*, 50 mg. (Barbituric Acid derivative; Warning: May be habit forming); Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Nicotinic Acid (Niacin), 10 mg. *U. S. Pat. Nos. 2,736,682; 2,809,916; 2,809,917; 2,809,918 and pat. pending.

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THE NEW DISEASE KNOWN AS WASHINGTONITIS

Austin Smith, M.D.

In the history of the United States of America freedom has been threatened many times. This country has known the meaning of war too many times. And it may know more about this word in the future. Involved always was freedom, if not for this country at least for other countries. But freedom can be lost on more than a battlefield. In fact, some countries have lost some of their freedom without a drop of blood being shed. Freedom in research, in teaching, in healing the sick is a kind of freedom over which physical wars seldom, if ever, are fought and yet it can be the means by which a country becomes a leader or is led.

In our own country we have seen emerge a belief held by many that business in general is irresponsible, that the professions and those who are scientifically trained are naive, and that only the paternalism of growing armies of government agencies can lead us safely along the path with one hand while with the other hand they extract cash from our pockets to pay for the expedition.

Three years ago, Earl W. Kintner, then chairman of the Federal Trade Commission, addressed a meeting of the Pharmaceutical Manufacturers Association, using as a title for his address the words "Com-

petitive Free Enterprise on Trial." Referring to a post World War II personal study of Germany under Hitler, he told of the steady deterioration of freedom in that country and observed that Hitler's Reich came to power under a constitution thought by many experts to be the most advanced and democratic constitution ever enacted. But its liberality contained its own seeds of destruction. As Kintner stated it, "The take-over was legal, and each deprivation of the people's freedom was accomplished in a methodical, legalistic manner."

Let me quote in part a few sentences from his address which, to me, offers a frightening note of sobriety as I consider some things that have occurred during the past two or three decades:

"President von Hindenburg in 1933 suspended certain sections of the Reich constitution relating to freedom of speech. . . . Then in 1935 the Reichstag abdicated its legislative authority in a law providing for decrees in the Reich Government which should come into force on the day following their promulgation by the Reich's Chancellor (Hitler) . . .

"On June 2, 1935, it was decreed:

"Whoever commits an act which the law declares is punishable, or which deserved punishment according to the fundamental idea of a penal law or the sound sentiment of the people, shall be punished. If no specific penal law can be directly applied to this act then it shall be punished according to the law whose indulging principle can be most readily applied to the act."

"Another law decreed on the same date provided for 'punishment according to the

(continued on page 74)

President, Pharmaceutical Manufacturers Association, Washington, D. C.

Adapted from a presentation made at annual meeting of Idaho State Medical Association, Sun Valley, Idaho, June 30, 1962.

Depend on low-cost,
low-dosage Prolixin
— once-a-day



Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects—Prolixin is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

THE
SQUIBB
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WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY
PROLIXIN®
SQUIBB FLUPHENAZINE HYDROCHLORIDE

SIDE EFFECTS, PRECAUTIONS, CONTRAINDICATIONS: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photo-sensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders.

AVAILABLE: 1 mg. tablets. Bottles of 50 and 500.

For full information, see your Squibb Product Reference or Product Brief.

SQUIBB



Squibb Quality—the Priceless Ingredient

WASHINGTONITIS

(continued from page 72)

common sense of the people' even if the act committed 'is not declared punishable by the law.' Courts were ordered in addition to 'effect an interpretation of the law which takes into account the change of ideology and of legal concepts which the new State has brought about.' "

Not for one moment would I want anyone to think that I am implying that responsible people in Washington are deliberately advocating by words or actions the overthrowing of our form of democracy. Nor am I suggesting that the administrative or legislative branches of our government are easy targets for those who might be advocates of such a change. No, what I am saying is simply this: Our way of life is of a form that lends itself to easy change. Freedom encourages attempts to cause change. A dictatorship on the other hand suppresses what freedom itself encourages because people are free to make suggestions, to try to influence others. Or as Kintner in effect said, a democracy because of its liberality contains the seeds of its own destruction.

Where the harm may arise is in circles populated by poorly informed people, by those whose philosophies lean more towards collectivism than individualism, and by those whose lack of experience limits their abilities to judge wisely when confronted with new problems. Personal ambitions, bouts of anger, and other temporarily troublesome factors have a way of being resolved in time since they represent normal human frailties rather than philosophies. But when put together all of these hurtful influences can create an overwhelmingly persuasive force which means that every now and then all of us should pause to ask a few simple questions: Where are we now? Where have we been? Where are we going? What should be done about it? Are we willing to personally do something about it? If so, how?

For some years we have seen an increasing tendency on the part of many people to

turn to Washington for guidance and help. And, believe me, there is no noticeable lack of enthusiasm about most federal offices applying Parkinson's law. Growth—bureaucratic expansion—is the order of the day. How much is necessary and how much represents sheer waste is an area in which I do not have special competence. As a close watcher of events in Washington and as a frequent visitor to offices where one can observe some intimate details of government activities, I am alarmed over what I see and hear. This country can be crippled as effectively through, for example, confiscatory taxation as through war. Often changes are advocated by persons without special training or knowledge. At times our critics and antagonists elsewhere in the world must watch with glee how we are trying to put on the shoes of corporate enterprise with academic shoe horns. Inevitably this leads to growth to compensate for weaknesses that in business circles would not be tolerated. Maybe an expressive indication of how government is growing on tax money is in the report that the number of federal employees increased in 1963 to 2,525,429 excluding military personnel. In 27 states there are more civilian federal workers than state employees.

Another indication of the extent to which government can become confusing for many of the uninitiated was evident in the 1959-1962 drug industry hearings. I will not bore you with the details: they can be found in part in the Congressional records. Criticisms there were, some justified, many not. Those justified could be true of any dynamic industry. The facts were there for those who wished to learn them. But in spite of facts, the investigation dragged on and on. In fact, Senator Roman L. Hruska, speaking at Fordham University, said they were "one of the longest, dreariest, most biased, most unfair, most cynical series of hearings which ever disgraced the United States Senate."

Despite testimony by renowned experts, comprehensive companion drug bills subsequently were introduced into the Senate and into the House. These bills perhaps

(continued on page 76)



with **Soma[®] Compound**

carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg.

In most patients with strains and sprains, 'Soma' Compound can reduce recovery time because of its ability both to relieve pain and to relax muscle. In a controlled study of patients in an industrial practice, R. G. Conant reported that 'Soma' Compound shortened recovery time an average of 25% as compared with aspirin.¹ In addition, complete or marked relief was noted in 94% of patients treated with 'Soma' Compound, as compared to 46% of patients treated with aspirin.

1. Conant, R. G.: Reduction of industrial time-loss: treatment with carisoprodol compound in musculoskeletal disorders. *Industr. Med. Surg.* 33:25, Jan. 1964.

Also available with ¼ gr. codeine as 'Soma' Compound with Codeine: carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

Indications: 'Soma' Compound and 'Soma' Compound with Codeine are useful for relief of pain and stiffness in traumatic, rheumatic and other conditions affecting muscles and joints. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol, phenacetin, or codeine phosphate. **Precautions:** *Phenacetin*—With long-term use, give cautiously to patients with anemia and cardiac, pulmonary, renal or hepatic disease. May damage the kidneys when used in large amounts or for long periods. *Caffeine*—Not recommended for persons extremely sensitive to its CNS stimulating action. *Codeine phosphate*—Use with caution in addiction-prone individuals. *Carisoprodol*—Carisoprodol, like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g. meprobamate. **Side effects:** Drowsiness, lightheadedness, dizziness, and gastric complaints have been reported infrequently for either or both of these preparations. *Phenacetin*—Side effects are extremely rare with short-term use of recommended doses. Prolonged ingestion of overdoses may produce dyspnea, cyanosis, hemolytic anemia, skin rash, anorexia, subnormal temperature, insomnia, headache, mental disturbances, and tolerance. *Caffeine*—Side effects are almost always the result of overdosage. Average doses may rarely cause nausea, nervousness, insomnia, and diuresis. Excessive dosage may produce, in addition, restlessness, nervousness, tolerance, tinnitus, tremors, scintillating scotomata, tachycardia, and cardiac arrhythmias. *Codeine phosphate*—Possible side effects are nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms. One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reaction, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression. **Dosage:** Usual adult dosage of 'Soma' Compound or 'Soma' Compound with Codeine is one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white capsule-shaped tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*



WALLACE LABORATORIES / Cranbury, N. J.

CSO-5155

WASHINGTONITIS

(continued from page 74)

reflected one of the symptoms of this new disease which might be called Washingtonitis. The resulting law—the Drug Amendments of 1962—contains more than 4,000 words to regulate just part of the actions of one industry. Representative Richard L. Roudebush of Indiana reports the Lord's Prayer has 56 words; Lincoln's Gettysburg Address, 266; the Ten Commandments, 297; and the Declaration of Independence, 300. But a recent Government statement on cabbage prices has 26,911! Probably the originator of this order never heard of the biblical advice: "He that hath knowledge spareth his words."

Verbosity and the application of Parkinson's law are not the only evidence of imbalance that can easily get out of hand. Attitudes are just as important. In time too, many tend to separate the government from the people. Then in time it becomes government versus the people. And finally those in government regard the people as working for them. For example, not long ago an official from the Treasury Department claimed the Government would not have any trouble balancing the budget if the American people would stop cheating on their income tax. As one editorial writer wrote: "Note that it is not the government's fault that it spends more than it takes in. It is the people's fault for not sending in as much as the government spends." Somehow this government philosophy seems to be to be a change from what Lincoln must have had in mind when he spoke of government of the people, by the people, for the people.

I would like to spend more time discussing money, as its use by government carries with it powerful influence. Too few realize the sums of money involved. Senator Harry F. Byrd recently stated that in fiscal year 1963 the government had the authority to obligate funds, outstanding Federal debt and other commitments of at least \$1.242 billion. This is \$1.24 trillion or more than four times the national debt approved by Congress.

Do you want to know how much it costs to adopt a "let the government do it attitude" rather than an "encourage the individual to do it" attitude? *Nation's Business* has reported the following figures:

Federal tax collections in

1930	.....\$	3 billion
1940	.....\$	5 billion
1950	.....\$	39 billion
1960	.....\$	92 billion
1963	.....\$	110 billion
1964	.....\$	114 billion
		(estimated)

National debt in—

1930	.....\$	16 billion
1940	.....\$	43 billion
1950	.....\$	257 billion
1960	.....\$	286 billion
1963	.....\$	295 billion
1964	.....\$	313 billion

(and a request has been approved by Congress to raise the ceiling another nine billion to \$324 billion). Interest on this mortgage takes more than nine cents out of each tax dollar. This reminds me of an advertisement recently published by Kohler Co. It read "When they investigate 'mislabeling,' wouldn't the dollar be a good place to start?"

One might normally hope for the watchdog committees in Congress to cope with waste and inefficiency but there are so few to do so much.

Regardless of the declared intentions of all committees and of both major political parties, government operations are just too big to cope with in detail except when there are special situations such as hearings on appropriations and investigations. And even here there is room for difficulty if party politics becomes important. For example, in this respect one might consider the imbalance in Senate and House staffs which can exist with either party in power. Bearing this in mind let's consider what might happen if party politics becomes important in an issue. According to columnist Roscoe Drummond, the proportion of staff experts on House committees responsible to the Democratic Party compared to those responsible to the Republi-

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restore activity
promptly with
Alertonic®***

Three tablespoonfuls (45 cc.) contain:

Pipradrol hydrochloride	2 mg.
Vitamin B ₁ (thiamine hydrochloride)	(10 MDR*) 10 mg.
Vitamin B ₂ (riboflavin)	(4 MDR*) 5 mg.
Vitamin B ₆ (pyridoxine hydrochloride)	1 mg.
Nicotinamide	(5 MDR*) 50 mg.
Choline†	100 mg.
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Cobalt (as chloride)	1 mg.
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*Multiple of adult Minimum Daily Requirement supplied

†Requirement in human nutrition not yet established

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knows no age***

Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

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WASHINGTONITIS

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can Party is 14 to 1. On the Senate side the majority staff numbers about 500 and the minority less than 100, a ratio of 5 to 1. This difference is not necessarily indicative of eventual faulty decision; it merely reflects the imbalance that can arise in our political system. And it is an example of the continuing need for public interest in the activities of those they elect to office. Sometimes they can lend support to these legislators. On other occasions they may see a need to sharply remind their legislators of other viewpoints.

Still an additional sign of the disease known as Washingtonitis is the readiness on the part of some segments of the public to take handouts. In research, education, and medical care this can assume staggering proportions in time. A science adviser to a former Secretary of State has reported that some universities receive more than 50 percent of their total operating budgets from government research grants. And more recently there have been some outspoken criticisms of inefficient use of some of the money being poured into medical research. The government now spends nearly \$15 billion yearly in research and development projects in defense, science and space. How this has grown is evident in the figures for research support. In 1940 the federal government's medical research expenditures were \$3 million, or about 7 percent of the total public and private medical research support. In 1961 they increased to \$496 million or 56 percent of the total. By 1970 it has been estimated to be \$1.6 billion or in excess of 70 percent of all research support.

Because there is so much activity in Washington, it is only natural, I suppose, to expect a flood of news releases from government agencies. And it is a flood. There are announcements of appointments, of grants of money, and copies of speeches in the mail every day. It's no wonder then that people in time will think first of all of the government as a place for leadership whether it be in the health field or else-

where. In fact, some time ago there appeared in the *Journal of the American Medical Association* the following observation:

"Public Health Service increasingly uses advisory committees to issue statements on medical care, statements which clearly should come from the medical profession."

Medical advice, if sound, is acceptable from any source and I am not criticizing the Public Health Service for issuing statements. I do say that government agencies and other offices have learned to use the press more effectively than have non-government groups and, as a result, some of the public thinks that progress is made only when government lends a hand. Think of the molding effect on many of a Department of Health, Education and Welfare news release which begins with the statement: "The Public Health Service has issued a 680-page volume listing the scientists supported through its research grant program, and containing an index to the content of their work. Since the Service supports about half of all the medical research in the United States, plus some in other countries, the index is by far the most exhaustive compilation of its kind ever made."

Sometimes members of the health professions are accused of selfishly being against change, particularly in the medical field. Frankly, I think this often is a most unkind accusation because I do not know of any group more eager to see change come about. We are spending our lives trying to bring about changes, in fact, in trying to put ourselves out of business. Therefore we are not against change. We only ask that the proposed change be based on fact, not theory; that it be given a revealing trial before it is nationally adopted. We want progress by evolution, not regression through revolution.

Sometimes, too, some of us, such as members of the pharmaceutical industry, are accused of being too anxious to proceed too quickly on too little. There is no excuse, in my judgment, for anyone proceeding in

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Fast symptomatic relief from seasonal hay fever comes in the convenient NTZ Nasal Spray bottle. Two sprays quickly relieve itching and decongest the nasal membranes on contact. The first spray of NTZ shrinks the turbinates, helps restore normal nasal ventilation and breathing. After a few minutes a second spray enhances sinus ventilation and drainage.

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Neo-Synephrine® HCl 0.5%, a decongestant of unexcelled efficacy to shrink nasal membranes.

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a summer hazard
prescribe
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Winthrop

WASHINGTONITIS

(continued from page 80)

the health field without fact. And yet those who criticize an occasional member of the pharmaceutical industry for such mistaken judgment say nothing over a press release from a government agency which begins with the words: "An experimental drug that may offer several potential advantages over the tranquilizer, reserpine, in the treatment of mild psychiatric disorders is now being tested in animals." Only in animals, and yet a press release is issued. Imagine how a drug company would be criticized for this. It would immediately be accused of trying to promote demand for an unproved drug. Apparently the source of such reports determines the extent of criticism.

Recently, I read an entertaining and yet provocative squib in a newspaper. It reads:

"Intellectuals have always contended that various forms of 'art' always reflect something of the national mood of the country which produces it.

"That the 'Twist' was invented in this country in 1961 fits easily into this general philosophy. It is a dance in which the lower and upper ends of the body go in one direction as the middle veers violently in the other, and in reversing the shifts, the ends meet the middle only in passing each other.

"This differs little from some of our governmental policies. Or should we say gyrations."

Maybe what I have been saying appears to have a critical air about it. I have not intended to criticize because some of the most dedicated people I have ever encountered are in public office, elective and administrative. But this is a big country and there are certain to be others with different viewpoints or less dedication. In a place like Washington, it is easy for some people to begin to believe that the world revolves around this city and that the people should work for the government. My only plea is to urge you to recognize that such a disease can become infectious and that unless you

practice some appropriate preventive medicine a nation can become infected.

Obviously, there's a place for government in our society. But there's also a place for the professional man, the business man, the laborer, the housewife, for all of us. The important challenge at the moment is to define the role for each. This can be done only by every one of us expressing our views and taking whatever action seems indicated.

Earl Kintner stated it when he said:

"I want only so much government control as is reasonably necessary to insure an orderly society in which there will be a maximum individual liberty and a competitive, free enterprise economic system in which there will be a maximum free market."

Obviously, adoption of this attitude imposes a sense of personal obligation on the part of each of us. He further stated:

"Both our political system and our economic system are grounded in the belief that the best society is the one which allows the individual the greatest opportunity for unfettered self-improvement. That belief in turn is grounded upon another article of faith, a faith that the individual in pursuing his self-development will demonstrate a decent respect for the needs of others, and a willingness to forego unlimited self-gratification at the expense of others. There is a deep realization that the exercise of the privilege of freedom entails the assumption of responsibility to others."

In other words, the spread of Washingtonitis is up to each of us. We can help preserve balance but it will require time, effort, even self-sacrificing expenditures. Or we can passively let Parkinson's law become dominant by doing nothing or at best waiting for others to do the job we should be doing. It's your future and my future that is involved. But let's not forget that it is also our children's future. And I think we are obligated to place in their hands a country as great as the one we received. To do otherwise is an act of betrayal.



How NALLINE® helps to keep the lid on drug addiction in California

NALORPHINE HCl
INJECTION U. S. P.

The use of the narcotic antagonist NALLINE® (nalorphine HCl injection U.S.P.), as a test of addiction, has significantly curtailed illicit narcotic traffic in Alameda County, California. In penal terms alone, three years after the institution of the test using NALLINE, prison admissions for addiction has dropped from 13.7% of total admissions to 4.4%.¹

The test was given to persons suspected of addiction and to addicts as a condition of probation or parole.

NALLINE does not cure addiction. It can, however, help addicts psychologically, because they know NALLINE detects relapse and that relapse leads to a return to prison or hospital. Definitive answers to the epidemiology of addiction—in itself a symptom of an underlying disease that may be psychologic, physiologic, or pharmacologic in nature—are, as yet, unknown.^{2,3}

The test should be undertaken only by physicians experienced in dealing with narcotic addicts.

INDICATIONS: To reverse significant respiratory depression due to opiates. Diagnostic—to test for opiate narcotic addiction.

CONTRAINDICATIONS: Do not use in mild or non-opiate respiratory depression.

PRECAUTIONS: Due to risk of violent withdrawal symptoms, use with extreme caution and in small doses in narcotic addicts and in

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SIDE EFFECTS: Untoward reactions include dysphoria, miosis, pseudoptosis, lethargy, drowsiness, sweating, pallor, nausea, psychomotoric manifestations.

Before prescribing or administering, read product circular with package or available on request.

Note: NALLINE will not precipitate abstinence symptoms in meperidine addicts unless they are taking 1,600 mg. or more daily. The ability of NALLINE to detect addiction to codeine is unknown.

References: 1. Brown, T. T.: The Enigma of Drug Addiction, Springfield, Ill., Charles C Thomas, 1961, pp. 287-334. 2. Chesnick, R. D.: Med. Times 90:247 (March) 1962. 3. Narcotic Addiction Symposium: New York Med. 18:562 (Aug. 20) 1962.

SUPPLIED: Ampuls of 1 and 2 cc. and vials of 10 cc., each cc. containing 5 mg. of nalorphine hydrochloride. **Note:** The Federal Bureau of Narcotics now classifies NALLINE as a Class M narcotic preparation. Thus, the purchase of this preparation no longer requires a Federal Narcotic Order Form.



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VOTING POWER OF THE HOUSE OF DELEGATES

1965 MEETING

	1st Session			2nd Session			3rd Session		
Officers and Trustees	18			18			17		
Speaker and Vice Speaker	2			2			2		
Past Presidents	7			8			5		
Delegates to the AMA	4			6			4		
Chicago Medical Society	69			58			57		
Downstate Delegates	81			85			78		
	181			177			163		

President—E. A. Piszczek	X	X	X	Raleigh C. Oldfield		X	X	
Pres-Elect—B. E. Montgomery	X	X	X	Leo P. A. Sweeney		X	X	X
1st V.P.—Carl F. Steinhoff	X	X		Arkell M. Vaughn				
2nd V.P.—L. T. Fruin	X		X	C. Paul White		X	X	
Secy-Treas.—Jacob E. Reisch	X	X	X					

Trustees:								
1st Dist.—Carl E. Clark		X	X					
2nd Dist.—R. N. Redmond	X	X	X					
3rd Dist.—Caesar Portes	X	X	X					
Frank J. Jirka	X	X	X					
Philip Thomsen								
J. Ernest Breed	X	X	X					
Wm. E. Adams		X	X					
Ted LeBoy	X	X	X					
4th Dist.—P. P. Youngberg	X	X						
5th Dist.—D. H. Trumpe	X	X	X					
6th Dist.—Newton DuPuy	X		X					
7th Dist.—A. F. Goodyear	X	X	X					
8th Dist.—W. H. Schowengerdt		X	X					
9th Dist.—C. K. Wells	X	X	X					
10th Dist.—W. C. Scrivner	X	X	X					
11th Dist.—Bernard Klein	X							
At-Large—Harlan English	X	X						
Speaker—E. W. Cannady	X	X	X					
Vice-Speaker—M. M. Hoeltgen	X	X	X					

AMA delegates								
(not duplicated elsewhere)								
Walter C. Bornemeier	X	X	X					
William K. Ford	X	X	X					
Frank H. Fowler	X	X	X					
H. Kenneth Scatliff	X	X	X					
Past Presidents								
Robert S. Berghoff								
Everett P. Coleman		X	X					
Rolland L. Green								
Edwin S. Hamilton	X	X	X					
Harry M. Hedge								
H. Close Hesseltnie	X	X	X					
Percy E. Hopkins	X	X	X					
James H. Hutton	X	X						
Willis I. Lewis								
George F. Lull								
Irving H. Neece								

COUNTY MEDICAL SOCIETIES

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ALEXANDER—James L. Crouse	X	X				
BOND—Max Fraenkel		X				
BOONE—John H. Steinkamp	X	X	X			
BUREAU—K. M. Nelson						
G. E. Giffin		X	X			
CARROLL—Eliseo M. Colli						
CASS-BROWN—B. A. DeSulis						
CHAMPAIGN—Carl Greenstein	X		X			
C. H. Walton	X	X	X			
CHRISTIAN—Ralph M. Seaton	X	X	X			
CLARK—Eugene P. Johnson		X	X			
CLAY—H. T. Fehrenbacher	X		X			
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Joseph R. O'Donnell	X	X	X			
J. P. Schweitzer	X	X	X			
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EDWARDS—Charles P. Salisbury						
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Peter Rumore			X			
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FORD—Paul W. Sunderland	X	X	X			
FRANKLIN—John P. Pope	X	X	X			
FULTON—Keith H. Frankhauser	X	X	X			
GALLATIN—John E. Doyle						

GREENE—Paul A. Dailey	X	X	X
HANCOCK—Byron I. Mueller	X	X	
HENDERSON—Silvino Lindo	X	X	X
HENRY—Paul M. Schmidt	X	X	X
IROQUOIS—R. Kent Swedlund	X	X	X
JACKSON—J. A. Petrazio	X	X	X
JASPER—Don L. Hartrich			
JEFFERSON—			
HAMILTON—Herman Rogers	X	X	X
JERSEY—Bernard Baalman		X	X
JoDAVIESS—A. L. Hildinger	X	X	X
JOHNSON—E. A. Veach	X	X	
KANE—John A. Newkirk	X	X	X
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B. F. Shirer	X	X	X
KANKAKEE—Donald A. Meier	X		X
KENDALL—Michael R. Saxon	X	X	X
KNOX—Fred Stansbury	X	X	X
LAKE—George B. Callahan	X	X	X
Donald Nellins	X		X
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LAWRENCE—Tom Kirkwood	X	X	X
LEE—Wm. A. McNichols		X	X
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McLEAN—A. Edward Livingston	X	X	X
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MACOUPIN—Joseph J. Grandone	X		
Augustinas Lancis		X	X
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MARION—Karl D. Venters	X	X	
MASON—J. W. McHarry	X	X	
MASSAC—George Green			
MENARD—Robert J. Schafer			
MERCER—M. E. Conway			
MONROE—Russell W. Jost	X	X	X
MONTGOMERY—			
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MORGAN—Albert F. Fricke	X	X	X
MOULTRIE—Eugene J. Boros			
OGLE—Russel W. Zack	X	X	X
PEORIA—Wm. O. McQuiston	X	X	X
Norman Powers	X	X	X
F. A. Christensen	X		X
PERRY—C. W. Cawvey	X	X	X
PIATT—Edgar W. Weir	X	X	X
PIKE-CALHOUN—			
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PULASKI—A. L. Robinson	X	X	
RANDOLPH—Rob't E. Schettler	X	X	X
RICHLAND—Wm. A. Moore	X		
ROCK ISLAND—J. G. Gustafson	X	X	X
Theodore Grevas		X	X
ST. CLAIR—Wm. H. Walton	X	X	X
V. P. Siegel	X	X	X
SALINE—N. A. Thompson	X	X	X
SANGAMON—Preston V. Dilts	X	X	X

Chauncey C. Maher, Jr.	X	X	
A. E. Steer	X	X	
SCHUYLER—Henry C. Zingher			
SHELBY—Duncan Biddlecombe	X	X	X
STEPHENSON—			
Thomas A. Haymond	X	X	
TAZEWELL—Roger Neumann	X	X	X
UNION—William H. Whiting			
VERMILION—G. L. Seitzinger	X	X	X
WABASH—William L. Walling			
WARREN—Kenneth E. Ambrose	X	X	X
WASHINGTON—			
Walter P. Plassman	X	X	X
WAYNE—C. J. Jannings	X	X	X
WHITE—S. B. Abelson			
WHITESIDE—C. J. Mueller	X	X	X
WILL-GRUNDY—Lloyd Jessen	X	X	X
Leonard F. Roblee	X	X	X
WILLIAMSON—Herbert Fine	X	X	
WINNEBAGO—Paul A. VanPernis	X	X	X
Harold E. Zenisek	X	X	X
F. A. Munsey	X	X	X
WOODFORD—Robert Lykkebak			

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C. Otis Smith	X		X
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Charles J. Weigel	X	X	X
Arthur E. Joslyn	X	X	X
A. G. Lawrence	X		
Herbert Ratner		X	X
Calumet Branch			
Donald Farmer	X	X	X
Stanley Ruzich	X		
Thaddeus Fial	X	X	
Harry Weisberg		X	
Douglas Park Branch			
Otto Koluvek	X		
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Colman J. O'Neill	X	X	
John D. McCarthy	X	X	X
Raymond Nemecek		X	X
Englewood Branch			
Marcello Gino			
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Frank C. Kwinn	X		X
Frank J. Saletta			X
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Irving Park Branch				Chester L. Crean	X		
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Fred A. Tworoger	X		X	Joseph R. DeCaro	X	X	X
David O. Dale	X		X	W. O. Ackley	X	X	X
Eugene M. Narsette	X	X	X	Philip M. Bedessem	X	X	
Alexander N. Ruggie				Edward C. Helfers		X	
Alfred Faber			X				
Jackson Park Branch				North Side Branch			
Wright Adams	X	X	X	Michael Boley	X		
Andrew J. Brislen	X	X	X	Roland R. Cross	X		
William J. Hand				Samuel L. Andelman	X	X	X
David S. Fox	X	X		William Hutchison	X		
Frank E. Maple				Anton Pantone	X		
Charles P. McCartney	X	X	X	Vincent Freda	X	X	X
				Jack Williams	X	X	
North Suburban Branch				Erwin M. Patlak	X	X	X
Robert A. Snyder		X	X	Clifton L. Reeder	X	X	X
Harold C. Lueth		X	X	Leonard Bressler	X		
C. Malcolm Rice, Jr.	X	X		John P. Malia		X	X
John L. Savage	X		X	Coye C. Mason		X	X
William Harridge	X						
Arnold Wagner	X			South Side Branch			
William Cummings	X	X		Jacob Epstein	X		
Frank Pirruccello				Robert R. Mustell	X	X	X
Raymond H. Conley	X	X	X	Alfred Klinger		X	
Northwest Branch				Southern Cook County Branch			
N. J. Kupferberg	X		X	Cyril Gallati			
M. J. Kutza	X	X		Frederick Weiss		X	
A. J. Linowiecki	X	X	X	Howard W. Schneider			
F. M. Nicholson	X						
R. V. Kochanski	X	X	X	Stock Yards Branch			
S. M. Goldberger		X	X	Glenn A. Burckart	X	X	X
M. A. Rydelski			X	E. J. Lukaszewski	X	X	X
South Chicago Branch				West Side Branch			
Tibor Czeisler		X	X	George Kaiser	X		
M. E. Finsky				Anna Marcus			
Simon Y. Saltman	X	X	X	Joseph F. O'Malley	X	X	X
Arthur W. Fleming	X	X	X				
				At Large			
North Shore Branch				Theo. R. VanDellen		X	X
George H. Irwin	X	X		Casper Epsteen	X	X	X
Burton Soboroff	X			A. L. Burdick, Sr.		X	X
C. A. Norberg	X	X	X	Harold A. Sofield	X	X	X
				Noel G. Shaw		X	X



Rx Reviews

and New Products

"Capillary Kidney"

Experiments with an "artificial kidney" made from plastic capillary tubes were described in a paper by scientists of The Dow Chemical Company and the University of Michigan at the recent Urological Research Forum in New Orleans.

Authors of the paper are Dr. Richard D. Stewart and Edward D. Baretta of the Medical Research Section of the Dow Biochemical Research Laboratory, Dr. Joseph C. Cerny of the University of Michigan Medical Center, and Henry I. Mahon of the Western Research Laboratories of Dow.

The authors of the article successfully accomplished hemodialysis in dogs with a unit made from cellulose triacetate capillaries. Each unit consisted of a bundle of 1,000 capillaries, six centimeters long. The inside diameter of the capillaries was 90 microns, and the wall thickness was 20 microns. The membrane surface area of the device was 170 square centimeters with an internal volume of 0.3 milliliters. Each bundle was sealed in a glass jacket fitted with a dialysate inlet and outlet.

Both in vitro and in vivo tests were conducted. In the former, solutions of urea, creatinine, uric acid, aspirin, barbituric acid, d-glucose and sodium barbiturate were passed through the capillary fibers and the clearance of these solutes from the fibers to the dialysate (distilled water) studied. Surface area for surface area, the deacetylated cellulose triacetate capillary membrane proved superior to the cellophane membrane used in the current commercial artificial kidneys for the removal of water and organic solutes.

The in vivo studies were performed on heparinized dogs anesthetized with intravenous pentobarbital. The femoral artery and vein were cannulated and the blood



Experimental artificial "kidney" developed by scientists of The Dow Chemical Company. This unit is composed of 1000 tiny plastic tubes sealed in a glass chamber. A similar kidney has been used successfully to perform the function of removing wastes from blood in a dog.

was pumped into the capillary bundle at a constant rate. Urea was dialyzed with the same efficiency as had been observed in the in vitro studies. The transfer of water from the blood in the capillaries through the membrane wall was measured. Significant amounts of water were selectively removed from the blood using nondeacetylated cellulose triacetate capillary bundles and the osmotic gradient produced by a 25 per cent calcium chloride wash solution.

The cellular elements in blood showed no signs of injury following contact with these fibers. However, despite adequate heparinization of the experimental animals, blood coagulation within the capillaries limited the duration of hemodialysis and water filtration.

The authors conclude that their studies have demonstrated that it is now technically feasible to construct an artificial kidney

(continued on next page)

from capillary fibers suitable for use in man. The small internal volume to large surface area ratio vital to the construction of an ideal dialyzer can be achieved readily with capillaries. A fiber bundle with a surface area of one square meter and an internal volume of only 50 milliliters could be made from capillaries 5.8 centimeters long and could operate at pressures less than 80 millimeters of mercury. Thus, the unit would not require donor blood for priming and could operate using the subject's arterial blood pressure without an external pump.

Major obstacle to the adaption of the techniques described in the paper to human use is the lack of units large enough for adult use. A number of problems remain in the production of the units on a large scale. If these problems can be overcome—and indications are that they can—the authors speculate that home dialysis for chronic renal failure would be feasible because of the simplicity, low cost and disposability of the capillary unit.

New Duracillin Dosage

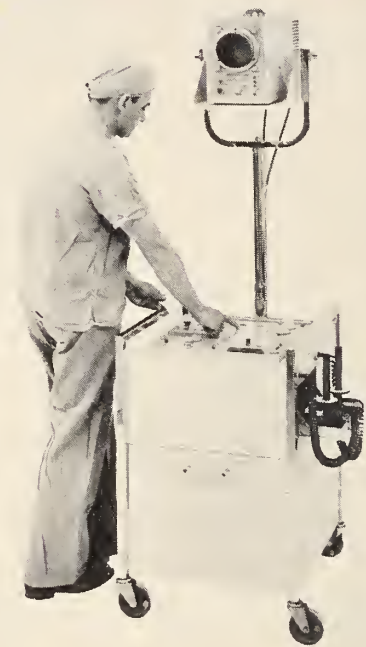
Eli Lilly and Company now offers Duracillin® A.S. (sterile procaine penicillin G aqueous suspension, U.S.P.) in a 1,200,000-unit Hyporet® (disposable syringe, Lilly).

This form of the long-acting penicillin is particularly useful in those kinds of infection which call for large doses. For example, in neurosyphilis the daily dosage is 1,200,000 units intramuscularly for ten days.

For greater flexibility in dosage, the new Hyporet No. 10 is marked with a blue line which permits the giving of a dose of 1,000,000 units.

Hyporets (No. 10) Duracillin A.S. are available in packages of 10 and 100. Each 2-cc. Hyporet has a 20-gauge needle and contains sodium citrate, 4 percent; Polysorbate 80, 0.15 percent; and 0.15 percent butyl-*p*-hydroxybenzoate as a preservative.

Heart Synchronized Depolarizer



A new instrument, called The Birtcher Heart Synchronized Direct Current Depolarizer, is announced by The Birtcher Corporation. For clinical use in reverting cardiac arrhythmias per the technic established by Lown, the new instrument depolarizes the patient's heart by means of a discharge through the chest of up to 400 watt seconds of direct current. The discharge is triggered at a pre-determined point in the patient's QRS complex by means of an electronic programmer which is built into the unit. The depolarization is timed so that the next impulse from the heart's own pacemaker will start a normal rhythm which can be maintained with minimum drug therapy. A large oil filled capacitor permits accurate build-up and storage of the DC charge, which is released through a special vacuum relay originally developed for advanced radar devices. A completely safe pre-test device is built-in, and the entire unit bears the Underwriters' Laboratories seal. Several models are available, ranging from the Depolarizer

alone for use as a DC Defibrillator through the unit shown, which is complete with programmer, built-in ECG and Monitor Scope. The unit can also be used with existing ECG and scope where they are already available. Full color descriptions will be sent on request. Write The Birtcher Corporation, 4371 Valley Boulevard, Los Angeles, California 90032.

Treatment of Burn Wounds

Care of serious burn wounds should be conservative, combined with an aggressive approach to skin grafting, according to Dr. Duane L. Larson, University of Texas Medical Branch, writing in the *Journal of Trauma* (5:254, March 1965).

Of critical importance in treating severely burned persons is early closure of open wounds in order to avoid bacterial infection. In the technique followed by Dr. Larson, closing wounds entails early excision and grafting or conservative debride-

ment and later application of the patient's own skin grafts. Skin grafts from other persons are usually used as an emergency, life-saving measure. Dr. Larson says if cadaver skin is to be used, it should be obtained under sterile conditions within six hours after death.

Citing the value of the conservative approach to wound care, he advises thorough washing of the patient's entire body, as well as the burn wound, with pHisoHex between the 7th and 10th post-burn day. The washing is done in the operating room under analgesia, and is followed by gentle-rinsing with an aerated water spray gun. Patients return to the operating room every two or three days for thorough washing, conservative debridement and application of dressings.

As soon as a healthy granulating surface is obtained, skin grafting is indicated. The suggested procedure for skin grafting includes insertion of an intravenous cath-

(continued on page 90)

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Rx Reviews (cont'd from page 89)

eter, a general anesthetic and liberal amounts of oxygen.

"The entire body should be washed with pHisoHex and rinsed with copious amounts of water since grafts will not adhere to granulations covered with soap or detergent material," the author says.

Regarding postoperative care, if dressings are applied to the grafted areas, Dr. Larson recommends removal of dressings in the operating room in three days in order to excise blebs and pustules, followed by a gentle cleansing with pHisoHex and water. Although a fresh dressing is applied, frequent exposure of the grafts is called desirable. Treatment also consists of constant physical therapy and a well-planned rehabilitation program.

Improved Vitamin B-12

Introduction of a new injectable long-lasting vitamin B-12 called Depinar 1 cc is

announced today by Pierre A. deTarnowsky, President of Armour Pharmaceutical Company.

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Depinar is packaged in boxes of ten 1 cc ampules. An average dose of Depinar 1 cc is 500 mcg. every two weeks and suggested maintenance dose is 500 mcg. each month.

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New Antianxiety Drug

SERAX® from Wyeth Laboratories, a more "flexible" new tranquilizer, has been approved under federal regulations that require manufacturers to prove both safety and efficacy of a new drug. Officials at the Philadelphia pharmaceutical manufacturer have received authorization from the Food and Drug Administration to market SERAX. Supplies of the drug are available now at distribution centers across the country.

Described as a versatile tranquilizer, SERAX (pronounced SAIR-AX) exerts prompt action in a wide variety of disorders associated with anxiety, tension, agitation and irritability and anxiety associated with depression. The new drug has been tested clinically in treating 4,240 patients and has been proven effective in patients displaying the symptoms of anxiety.

In tolerance and toxicity studies on several animal species, the new drug reveals significantly greater safety factors than re-

lated compounds and manifests a wide separation of effective doses and doses inducing side effects.

SERAX was developed by Wyeth's research scientists during a six-year search for a new drug that would be effective on medium-range anxiety symptoms but would cause less drowsiness and loss of muscular control than other tranquilizers.

After developing and testing many compounds that affect the central nervous system, the Wyeth researchers selected oxazepam (marketed as SERAX) because their tests indicated the compound would act promptly but would have fewer side effects than other drugs.

Available on prescription only, SERAX has been called "flexible" because tests indicate that the drug has a wide range between the minimum effective dose and a dose which might cause side effects such as sedation and ataxia. Thus the physician may individualize the dosage to give maximum benefits to patients exhibiting a wide range of emotional disturbances.

This versatility in SERAX was borne out in the extensive clinical studies. Physicians in private practice found that the anti-anxiety drug could be prescribed safely. Also, these clinical trials indicated the drug is well tolerated in elderly patients. SERAX was effective in controlling and quieting geriatric patients with greater safety than similar drugs.

Side effects from SERAX have been described as "mild and transient." In the analysis of more than 4,240 patients treated with SERAX, only 14% of those treated showed any side effects. About half of the side effects reported were drowsiness. Less than three per cent of the patients treated with the new drug had to discontinue the therapy because of side effects. In two cases when patients tried to commit suicide by taking large overdoses of the drug, both were examined in a hospital and recovered with no special treatment.

Because of the flexibility of SERAX and the range of emotional disturbances responsive to it, a physician will be able to set each dosage for maximum benefits for the patient.

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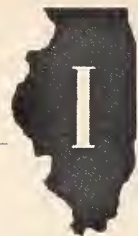
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Clyde R. Goodheart, M.D.

Appointments

Five scientists have been named to the staff of the Institute for Biomedical Research—newest center for investigation of basic life processes.

The appointments were announced today by Raymond M. McKeown, M.D., president of the American Medical Association Education and Research Foundation which is the parent organization of the Institute.

Dr. McKeown said while research work at the Institute will begin next month, the laboratory building—an addition to AMA headquarters—will not be dedicated until this fall.

Those who have accepted research positions with the Institute are:

* George R. Collins, former supervisor of the Animal House Department at the Rockefeller Institute. Collins will head the

animal research facility at the Institute and continue research in epizootology—the study of animal diseases.

* Clyde R. Goodheart, M.D., associate professor of pediatrics at the University of Southern California School of Medicine and virologist at Children's Hospital of Los Angeles. His present research includes the study of intracellular mechanisms in an attempt to explain how viruses may cause cells to become malignant.

* Roy E. Ritts, Jr., M.D., director of the Institute, who will continue studies of the cellular mechanism of delayed-type hypersensitivity. Better understanding of these reactions could be of great value in overcoming the rejection of transplanted tissues and organs.

* Howard A. Schneider, Ph.D., currently director of the laboratory of experimental
(continued on page 95)



Roy E. Ritts, Jr., M.D.

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SPECIALTY REVIEW COURSE IN GYN-OB,
Two Weeks, October 25
PRINCIPLES OF OPERATIVE SURGERY, Two Weeks, October 4
SURGERY OF STOMACH & DUODENUM, One Week,
September 20
PROCTOSCOPY & SIGMOIDOSCOPY, One Week, August 16
TREATMENT OF VARICOSE VEINS, One Week, August 16
SURGERY OF THE HAND, One Week, September 13
PEDIATRIC SURGERY, One Week, September 20
SURGERY OF FACE & MOUTH, One Week, October 11
ADVANCES IN SURGERY, One Week, October 4
ADVANCES IN MEDICINE, One Week, October 4
ADVANCES IN OB-GYN, One Week, October 4
FRACTURES & TRAUMATIC SURGERY, Two Weeks,
September 20
BASIC ELECTROCARDIOGRAPHY, One Week, September 27
CLINICAL USES OF RADIOISOTOPES, Two Weeks, October 4
VAGINAL SURGERY, One Week, August 2
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The physician will be Medical Director of the Health Unit and will supervise a staff of three nurses, receptionist, and matron. The administrative responsibilities and financial support will be carried by GSA of the U. S. Government.

Hours of operation of the health services will be from 8:30 A.M. to 5:00 P.M., Monday thru Friday, to give a forty (40) hour week. All eight (8) Federal Holidays will be observed.

The General Services Administration proposes to contract with a physician or physicians group for the medical services required in the Health Unit at a salary of \$16,000 to \$18,000 per year.

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OBITUARIES

Warren J. Lage, Rock Island, died December 12, aged 46. A graduate of St. Louis University School of Medicine in 1943, he served in the medical reserve corps of the U.S. Army and was associated with the Veterans Administration.

Francisco J. Lardizabal, Elmhurst, died May 1, aged 63. A graduate of medical school in Manila, he was a staff member of the West Side Veterans hospital for the last six years and had been state surgeon general of the Amvets.

Ruth Leonard*, Rockford, died May 4, aged 75. In 1920 she was a graduate of the University of Illinois College of Medicine and specialized in obstetrics and gynecology. In 1921 she went to Shanghai, China, where she practiced for six years, returning to Rockford where she practiced until her retirement in 1962. She had been on the staff of both Rockford Memorial and Swedish American hospitals. She was an Emeritus member of ISMS.

Adolph C. Midthun*, Oak Park, died May 11, aged 71. Originally from Norway, he graduated from Chicago Medical College in 1926. He was an insurance doctor for 35 years and had been surgical consultant to the same company for the last 10 years. He retired in 1961.

Louis D. Minsk*, Evanston, died May 30, aged 76. In 1913 he was a graduate of Johns Hopkins University School of Medicine. He had been chief of pediatrics at St. Francis hospital since 1930 and he was also medical director for the Cradle Society of Evanston and the Infant Welfare Society. He was an Emeritus member and a member of the Fifty Year Club of ISMS.

Charles E. Pitte*, Chicago, died May 17, aged 73. A graduate of the Chicago College of Medicine & Surgery in 1914, he practiced for 50 years prior to his retirement. He was a member of the Fifty Year Club of ISMS.

Hertha K. Sorter, Chicago, died May 23, aged 64. A graduate of Medizinische Fakultät der Universität, Vienna, in 1935, she retired in 1963. She was formerly a staff member of Michael Reese hospital for 30 years and spent 10 years as director of the Drexel Home and Rest Haven Convalescent Home.

Giovanni Stranges, Chicago, died May 11, aged 87. He was a graduate of the Università di Napoli, Facoltà di Medicina e Chirurgia, Italy, in 1904.

Frank C. Winters*, Monmouth, died June 1, aged 83. A graduate of the University of Illinois College of Medicine in 1912, he was an E.E.N.T. specialist. An Emeritus member of ISMS, he was also a member of the Fifty Year Club.

John E. Zaremba, Chicago, died May 21, aged 80. In 1917 he was a graduate of the Illinois Medical College.

**Indicates member of Illinois State Medical Society.*

NEWS and ANNOUNCEMENTS

(continued from page 92)

ecology at the Rockefeller Institute. Dr. Schneider is investigating the nature of natural resistance to infectious disease and a possible new mechanism—apart from immunity of antibiotic action—for altering or enhancing the host's resistance to infecting microorganisms.

* Dan W. Urry, Ph.D., post-doctoral fellow in chemistry at Harvard University. Dr. Urry is studying the structure and conformation of biological molecules, such as proteins, co-enzymes, nucleotides, and amino acids. An appreciation of the interplay of such molecules is basic to further understanding of their role in the life processes.

In describing the nature of the Institute Dr. McKeown pointed out, "This research facility's resources are its scientists, not its projects.

"In other words we intend to support the man—provide him the opportunity to

press his research in whatever direction seems best to him—rather than hold him to work within the confines of a specific project."

Elections

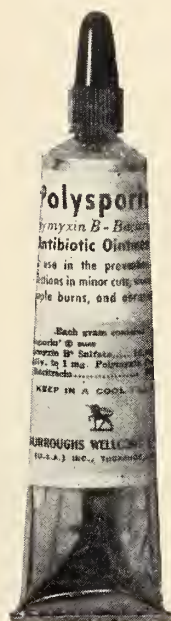
Stanton A. Friedberg, M.D., has been re-elected president of the 400-member medical staff of Presbyterian-St. Luke's Hospital. This is Dr. Friedberg's second term.

Dr. Friedberg is chairman of the hospital's otolaryngology and bronchoesophagology department. He was graduated from Rush Medical College in 1933. He served both his internship and residency at Presbyterian Hospital and was appointed to the hospital's medical staff in 1937.

Ormand C. Julian, M.D., attending surgeon specializing in cardio-vascular surgery, has been re-elected vice president of the staff. Robert E. Slayton, M.D., associate attending physician, has been named secretary. Bertram G. Nelson, M.D.,

(continued on page 96)

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NEWS and ANNOUNCEMENTS

(continued from page 95)

attending physician, has been elected treasurer.

The following officers have been elected to the Chicago Neurological Society for the term May 1965 through May 1966:

President—Dr. Louis D. Boshes; Vice-President—Dr. Joseph A. Tarkington; Secretary—Dr. Harold Koenig; Councilor—Dr. Sidney Schulman.

Fellowships

Four doctors from Denmark, Germany, India and Colombia are the first recipients of the annual Merck Sharp & Dohme International Fellowships in Clinical Pharmacology, Dr. Dickinson W. Richards, chairman of The Merck Company Foundation's six-member selection committee, announced.

The Fellowship program provides a total of \$90,000 annually for postgraduate study in the United States and is designed to seed other countries with experts in clinical pharmacology, physicians who plan to devote themselves to medical education and drug research. According to Dr. Richards, professor emeritus at Colombia University and a Nobel prize winner, the grants will finance up to two years of study for eight physicians at a time, with four being chosen each year.

In addition to defraying full tuition and fees, the Fellowships provide a basic stipend of \$400 monthly plus family allowances of \$100 monthly for wife and \$50 for one child or \$100 for two. Basic travel expenses are also covered.

Crippled Children's Clinic for August

August 4 Alton Rheumatic Fever & Cardiac—Alton Memorial Hospital
August 4 Hinsdale—Hinsdale Sanitarium
August 5 Litchfield—Madison Park School
August 5 Macomb—McDonough District Hospital
August 6 Chicago Heights Cardiac—St. James Hospital
August 10 Peoria General—Children's Hospital
August 10 East St. Louis—St. Mary's Hospital
August 11 Champaign-Urbana—McKinley Hospital
August 12 Springfield General—St. John's Hospital
August 13 Evanston—St. Francis Hospital
August 17 Belleville—St. Elizabeth's Hospital
August 18 Chicago Heights General—St. James Hospital
August 19 Rockford—Rockford Memorial Hospital
August 19 Bloomington (A.M.)—St. Joseph's Hospital
August 19 Elmhurst Cardiac—Memorial Hospital of DuPage County
August 20 Chicago Heights Cardiac—St. James Hospital
August 24 Peoria General—Children's Hospital
August 25 Springfield Cerebral Palsy (P.M.)—Memorial Hospital
August 25 Aurora—Copley Memorial Hospital
August 26 Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital



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MAJOR REFERENCE SECTIONS:

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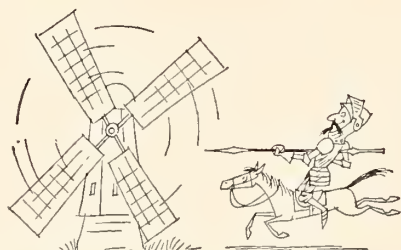
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References: 1. Scal, J. C.: Eye Ear Nose & Throat Month. 38:738 (Sept.) 1959. 2. Based on 1964 data from independent physicians' market survey organization.



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Foreword

IN AUGUST OF 1964 the *Illinois Medical Journal* published the first reference issue for the membership of the Illinois State Medical Society, and incorporated as many subjects as officers and staff could justify and prepare for publication.

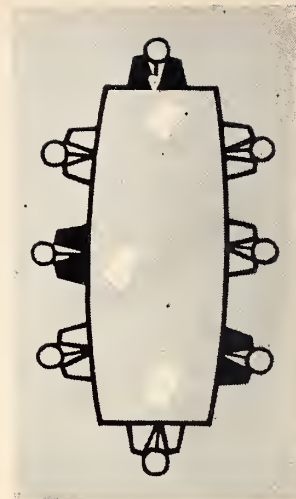
In this 1965 issue, the second to appear, you will find some of the material reprinted; some changed drastically and some eliminated altogether.

With 12 months' experience, we feel that again we are offering you an issue to be kept carefully and used throughout the next year for ready reference.

Please feel free to contact the officers, trustees or staff and make suggestions for the continued improvement of this service for our membership.

A handwritten signature in dark ink, appearing to read 'B. E. Montgomery, M.D.' with a stylized flourish at the end.

BURTIS E. MONTGOMERY, M.D.
PRESIDENT



ISMS ORGANIZATION

History of Founding and Expansion

TWENTY-NINE PHYSICIANS met in Springfield June 4, 1850, and organized the Illinois State Medical Society. They were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted; the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1958. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960.

The Society published the early transactions in book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1898 a new

era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pennee with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen and Dr. Theodore R. Van Dellen is the editor today.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922 he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

LIST OF OFFICERS AND PLACES OF MEETING SINCE ORGANIZATION OF THE SOCIETY

YEAR	PRESIDENT	SECRETARY	TREASURER	MEETING PLACE
1840	John Todd	David Prince		Springfield
1850	Rudolph Rouse	Edwin G. Meek		Springfield
1850	William B. Herriek	Edwin G. Meek	Jno. Halderman	Springfield
1851	Samuel Thompson	H. Shoemaker	R. Rouse	Peoria
1852	Rudolph Rouse	E. S. Cooper	Edw. Dickenson	Jacksonville
1853	Daniel Brainerd	H. A. Johnson	A. B. Chambers	Chicago
1854	C. N. Andrews	H. A. Johnson	N. S. Davis	LaSalle
1855	N. S. Davis	E. Andrews	J. V. Z. Blaney	Bloomington
1856	H. Noble	N. S. Davis	J. V. Z. Blaney	Vandalia
1857	C. Goodbreak	H. A. Johnson	J. V. Z. Blaney	Chicago
1858	H. A. Johnson	N. S. Davis	J. W. Freer	Rockford
1859	David Prince	N. S. Davis	J. W. Freer	Decatur
1860	Wm. M. Chambers	N. S. Davis	J. W. Freer	Paris
1863	A. McFarland	N. S. Davis	J. H. Hollister	Jacksonville
1864	A. H. Luce	N. S. Davis	J. H. Hollister	Chicago
1865	J. M. Steele	N. S. Davis	J. H. Hollister	Bloomington
1866	F. F. Haller	N. S. Davis	J. H. Hollister	Decatur
1867	H. Noble	N. S. Davis	J. H. Hollister	Springfield
1868	S. T. Trowbridge	N. S. Davis	J. H. Hollister	Quincy
1869	S. T. Trowbridge	T. D. Fitch	J. H. Hollister	Chicago
1870	J. V. Z. Blaney	T. D. Fitch	J. H. Hollister	Dixon
1871	G. W. Albin	T. D. Fitch	J. H. Hollister	Peoria
1872	J. O. Hamilton	T. D. Fitch	J. H. Hollister	Rock Island
1873	D. W. Young	T. D. Fitch	J. H. Hollister	Bloomington
1874	T. F. Worrell	T. D. Fitch	J. H. Hollister	Chicago
1875	J. H. Hollister	T. D. Fitch	Wm. E. Quine	Jacksonville
1876	T. D. Washburn	N. S. Davis	J. H. Hollister	Urbana
1877	T. D. Fitch	N. S. Davis	J. H. Hollister	Chicago
1878	J. L. White	N. S. Davis	J. H. Hollister	Springfield
1879	E. P. Cook	N. S. Davis	J. H. Hollister	Lincoln
1880	Ephraim Ingalls	N. S. Davis	J. H. Hollister	Belleville
1881	G. W. Jones	S. J. Jones	J. H. Hollister	Chicago
1882	Robert Boal	S. J. Jones	J. H. Hollister	Quincy
1883	A. T. Darrah	S. J. Jones	J. H. Hollister	Peoria
1884	E. Andrews	S. J. Jones	Walter Hay	Chicago
1885	D. S. Booth	S. J. Jones	Walter Hay	Springfield
1886	Wm. A. Byrd	S. J. Jones	Walter Hay	Bloomington
1887	Wm. T. Kirk	D. W. Graham	Walter Hay	Chicago
1888	Wm. O. Ensign	D. W. Graham	Walter Hay	Rock Island
1889	C. W. Earle	D. W. Graham	T. W. Melvaine	Jacksonville
1890	John Wright	D. W. Graham	T. W. Melvaine	Chicago
1891	Jno. P. Mathews	D. W. Graham	Geo. N. Kreider	Springfield
1892	Charles C. Hunt	D. W. Graham	Geo. N. Kreider	Vandalia
1893	E. Fletcher Ingals	D. W. Graham	Geo. N. Kreider	Chicago
1894	Otho B. Will	J. B. Hamilton	Geo. N. Kreider	Decatur
1895	Daniel R. Brower	J. B. Hamilton	Geo. N. Kreider	Springfield
1896	D. W. Graham	J. B. Hamilton	Geo. N. Kreider	Ottawa
1897	A. C. Corr	J. B. Hamilton	Geo. N. Kreider	East St. Louis
1898	J. N. G. Carter	E. W. Weis	Geo. N. Kreider	Galesburg
1899	J. T. Pitner	E. W. Weis	Geo. N. Kreider	Cairo
1900	H. N. Moyer	E. W. Weis	Geo. N. Kreider	Springfield
1901	G. N. Kreider	E. W. Weis	E. J. Brown	Peoria
1902	J. T. McAnally	E. W. Weis	E. J. Brown	Quincy
1903	M. L. Harris	E. W. Weis	E. J. Brown	Chicago
1904	C. E. Black	E. W. Weis	E. J. Brown	Bloomington
1905	W. E. Quine	E. W. Weis	E. J. Brown	Rock Island
1906	H. C. Mitchell	E. W. Weis	E. J. Brown	Springfield
1907	J. F. Percy	E. W. Weis	E. J. Brown	Rockford
1908	W. L. Baum	E. W. Weis	E. J. Brown	Peoria
1909	J. W. Pettit	E. W. Weis	E. J. Brown	Quincy

YEAR	PRESIDENT	SECRETARY	TREASURER	MEETING PLACE
1910	J. L. Wiggins	E. W. Weis	E. J. Brown	Danville
1911	A. C. Cotton	E. W. Weis	E. J. Brown	Aurora
1912	W. K. Newcomb	E. W. Weis	E. J. Brown	Springfield
1913	L. H. A. Nickerson	E. W. Weis	A. J. Markley	Peoria
1914	Charles J. Whalen	W. H. Gilmore	A. J. Markley	Decatur
1915	A. L. Brittin	W. H. Gilmore	A. J. Markley	Springfield
1916	C. W. Lillie	W. H. Gilmore	A. J. Markley	Champaign
1917	W. L. Noble	W. H. Gilmore	A. J. Markley	Bloomington
1918	E. B. Coolley	W. H. Gilmore	A. J. Markley	Springfield
1919	E. W. Fiegenbaum	W. H. Gilmore	A. J. Markley	Peoria
1920	J. W. Van Derslice	W. H. Gilmore	A. J. Markley	Rockford
1921	W. F. Grinstead	W. H. Gilmore	A. J. Markley	Springfield
1922	Charles Humiston	W. H. Gilmore	A. J. Markley	Chicago
1923	E. P. Sloan	W. D. Chapman	A. J. Markley	Decatur
1924	E. H. Ochsner	W. D. Chapman	A. J. Markley	Springfield
1925	L. C. Taylor	H. M. Camp	A. J. Markley	Quincy
1926	J. C. Krafft	H. M. Camp	A. J. Markley	Champaign
1927	Mather Pfeifferberger	H. M. Camp	A. J. Markley	Moline
1928	G. Henry Mundt	H. M. Camp	A. J. Markley	Chicago
1929	J. E. Tuite	H. M. Camp	A. J. Markley	Peoria
1930	F. O. Fredrickson	H. M. Camp	A. J. Markley	Joliet
1931	Wm. D. Chapman	H. M. Camp	A. J. Markley	East St. Louis
1932	R. R. Ferguson	H. M. Camp	A. J. Markley	Springfield
1933	John R. Neal	H. M. Camp	A. J. Markley	Peoria
1934	Philip H. Kreuscher	H. M. Camp	A. J. Markley	Springfield
1935	Charles D. Center*			
	(Past President-Elect)			
1935	Charles S. Skaggs	H. M. Camp	A. J. Markley	Rockford
1936	Chas. B. Reed	H. M. Camp	A. J. Markley	Springfield
1937	Rolland L. Green	H. M. Camp	A. J. Markley	Peoria
1938	R. K. Packard	H. M. Camp	A. J. Markley	Springfield
1939	S. E. Munson	H. M. Camp	A. J. Markley	Rockford
1940	Jas. H. Hutton	H. M. Camp	A. J. Markley	Peoria
1941	J. S. Templeton	H. M. Camp	A. J. Markley	Chicago
1942	Chas. H. Phifer	H. M. Camp	H. M. Camp	Springfield
1943	E. H. Weld	H. M. Camp	H. M. Camp	Chicago
1944	G. W. Post**	H. M. Camp	H. M. Camp	Chicago
1945	E. P. Coleman***	H. M. Camp	H. M. Camp	
1946	E. P. Coleman	H. M. Camp	H. M. Camp	Chicago
1947	R. S. Berghoff	H. M. Camp	H. M. Camp	Chicago
1948	I. H. Neece	H. M. Camp	H. M. Camp	Chicago
1949	Percy E. Hopkins	H. M. Camp	H. M. Camp	Chicago
1950	Walter Stevenson	H. M. Camp	H. M. Camp	Springfield
1951	Harry M. Hedge	H. M. Camp	H. M. Camp	Chicago
1952	C. Paul White	H. M. Camp	H. M. Camp	Chicago
1953	Leo P. A. Sweeney	H. M. Camp	H. M. Camp	Chicago
1954	Willis I. Lewis	H. M. Camp	H. M. Camp	Chicago
1955	Arnell M. Vaughn	H. M. Camp	H. M. Camp	Chicago
1956	F. Garm Norbury	H. M. Camp	H. M. Camp	Chicago
1957	F. Lee Stone	H. M. Camp	H. M. Camp	Chicago
1958	Lester S. Reavley	H. M. Camp	H. M. Camp	Chicago
1959	Raleigh C. Oldfield	H. M. Camp	H. M. Camp	Chicago
1960	Joseph T. O'Neill	George F. Lull	George F. Lull	Chicago
1961	H. Close Hesseltine	Jacob E. Reisch	Jacob E. Reisch	Chicago
1962	Edwin S. Hamilton	Jacob E. Reisch	Jacob E. Reisch	Chicago
1963	George F. Lull	Jacob E. Reisch	Jacob E. Reisch	Chicago
1964	Harlan English	Jacob E. Reisch	Jacob E. Reisch	Chicago
1965	Edward A. Piszczek	Jacob E. Reisch	Jacob E. Reisch	Chicago
1966	Burtis E. Montgomery	Jacob E. Reisch	Jacob E. Reisch	Chicago

*Died before induction into office

**Died in office. Term completed by Robert S. Berghoff, First Vice President

***Meeting cancelled 1945

PRINCIPLES OF MEDICAL ETHICS

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

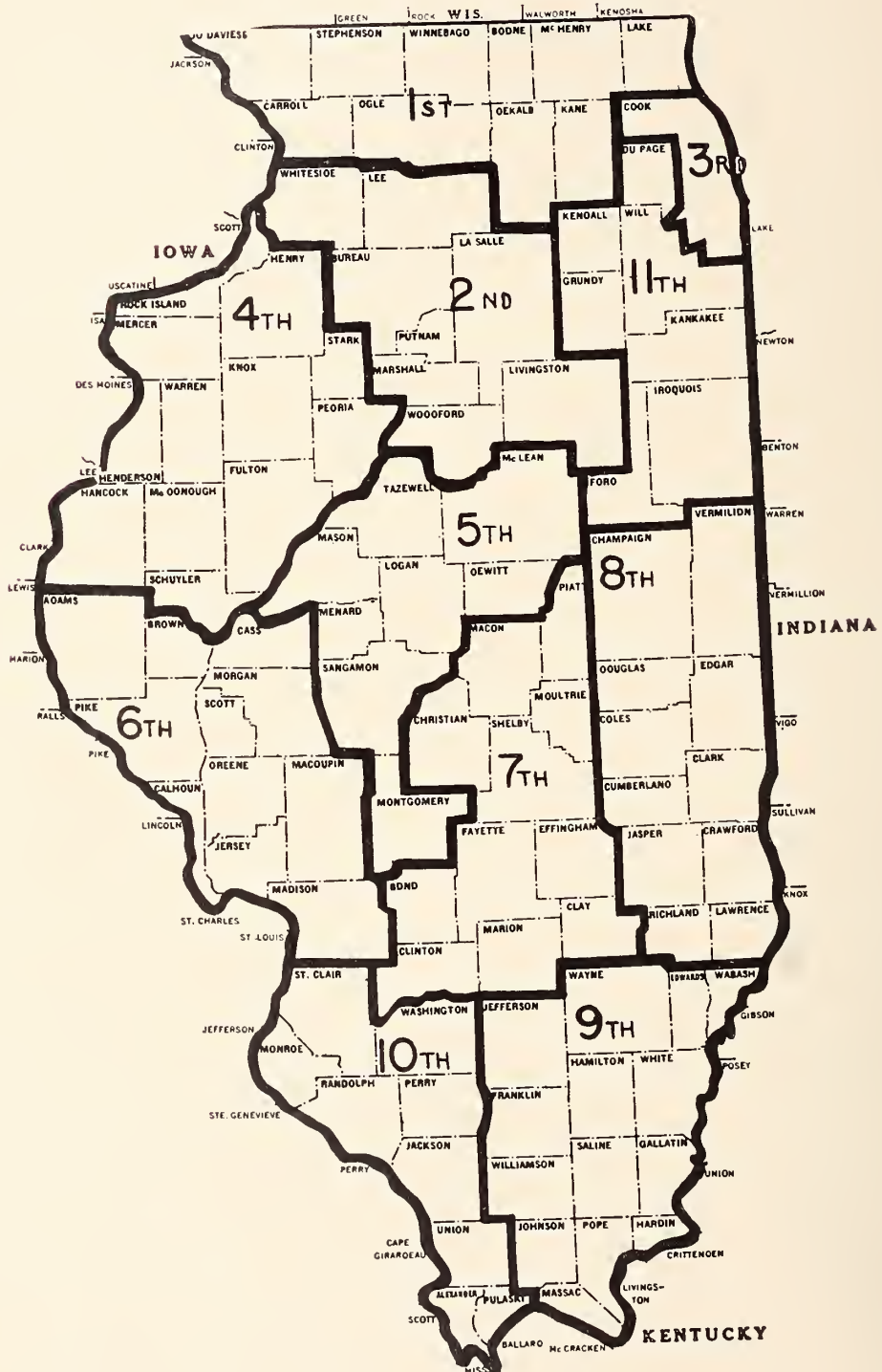
SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

MAP OF TRUSTEE DISTRICTS



CONSTITUTION AND BYLAWS

MAY 1965

Adopted, 1903
As Amended 1965

Constitution

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

ARTICLE VI. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates and general scientific meetings which shall be open to all registered members.

ARTICLE VIII. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, sixteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

Bylaws

CHAPTER I. MEMBERSHIP

Section 1. *Members.*

A. *Active Members.* The active members of this Society shall consist of regular members, emeritus members, retired members, provisional members, intern members and residency members. Active members shall enjoy full privileges which include membership in the American Medical Association.

B. *Special Members.* The special members of this Society shall be distinguished because of their contributions to the science and art of medicine.

(1) *Distinguished Members.* Distinguished members shall be:

a. Physicians of Illinois or other states, or foreign countries who have risen to prominence in the profession; or

- b. Teachers of medicine or of the sciences allied to medicine, not eligible for active membership; or
 - c. Members of associated arts or sciences who have made significant contributions to medicine.
- (2) *Election.* Special members may be nominated by any member of the House of Delegates, and may be elected by the House at any annual convention by a two-thirds vote.
- (3) *Privileges.* Special members shall not be entitled to hold office nor to vote, and shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other Society activities.

Section 2. *Qualifications for Membership.*

- A. Every physician duly licensed and registered in the State of Illinois to practice medicine in all its branches who is a graduate of a medical school approved in United States or Canada, a resident of the State of Illinois, a citizen of the United States, who is of good moral character and professional standing, and a member of his component medical society, shall be eligible for regular membership.
- B. Provisional membership shall be available to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this State to practice medicine in all of its branches, and who—with the exception of United States citizenship—possesses all of the qualifications for membership prescribed by these Bylaws. Provisional membership shall terminate one year after the expiration of the minimum period of time within which such member could have perfected his citizenship. After obtaining full citizenship and prior to the expiration of his provisional membership, such member may be, upon application to his component medical society, transferred to regular membership.
- C. The following shall also be eligible if approved and recommended by the component medical society:
- (1) Every physician serving as a full time employee at the headquarters of the American Medical Association;
 - (2) Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively in their respective service, and thereafter, if they have been retired on account of age or physical disability, or after long and honorable

service under the provision of an Act of Congress;

- D. Physicians otherwise eligible for membership, and licensed in one of the States of the Union, but not licensed in Illinois, and who are not engaged in the active practice of medicine, but otherwise employed in an allied medical activity which does not require licensure, shall be eligible for membership if approved and recommended by the component medical society and approved by the Board of Trustees.

Section 3. *Emeritus Members.* A member who has been in good standing for thirty-five years and who has reached the age of seventy, may upon application to and upon recommendation of his component society, be made an emeritus member and have all the rights and privileges of membership without the payment of dues to the component or state society.

Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.

Section 4. *Retired Members.* A member who has been in good standing but who by reason of age or incapacity, has retired from active practice, may upon application to and upon recommendation of his component society, be made a retired member, without payment of dues to the component or state society.

Section 5. *Intern Members.* Any person who is a graduate of a medical school approved in the United States or Canada, who is of good moral character and professional standing and who is serving an internship in any hospital in the State of Illinois approved by the American Medical Association, is eligible for intern membership upon the recommendation of any two members of this Society who are also members of his hospital staff.

The physician's intern membership shall cease at the end of the year in which his internship training terminates, and if he wishes to become a member of this Society, he must apply for a residency or regular membership through his component society.

Dues for intern membership shall be minimal.

Section 6. *Residency Members.* After being licensed to practice medicine, a physician serving full time as a resident in a residency approved by the American Medical Association, is eligible for full membership.

Dues for residency members shall be minimal.

A residency member must be a graduate of a medical school approved in the United States or Canada, have a degree of Doctor of Medicine or its equivalent, and must be a member in good standing of his component society.

The physician's residency membership shall cease at the end of the year in which his residency

training terminates, and if he wishes to become a member of this Society, he must apply for regular membership through his component society.

Section 7. *Tenure of Membership.* The name of a physician on the properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this Society, and afford all the rights and privileges pertaining thereto.

Section 8. *Withdrawal of Privileges.* No person who is under sentence of suspension or expulsion from a component society, shall be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of the proceedings until he has been reinstated.

CHAPTER II. ANNUAL CONVENTIONS

Section 1. *Date.* The Board of Trustees shall determine the date for the annual convention.

Section 2. *Meeting Place.* The meeting place for the annual convention shall be determined by the House of Delegates from a list of cities extending invitations, subject to investigation of the facilities and approval by the Board of Trustees.

Section 3. *Scientific Meetings.*

- A. With the consent of the House of Delegates or the Board of Trustees any special group may conduct its meeting in connection with the annual convention of this Society.
- B. For the transaction of scientific business, there shall be one or more sections as may be determined from year to year by the Board of Trustees.
- C. Section officers shall be appointed by the president of the Society from nominees recommended by the section, or if there are no nominees, from a list submitted by the chairman of the Committee on Scientific Assembly.
- D. The officers of the sections shall arrange the scientific program for the section in cooperation with the Committee on Scientific Assembly.
- E. All registered members may attend and participate in the proceedings and discussions of the general scientific meetings and of the section meetings.
- F. The general scientific meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and to the public.
- G. All papers read before the Society or any section thereof, shall become the property of the Society. Each paper shall be deposited with the secretary when read, and presentation of a paper to the Illinois State Medical Society shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published.

H. The Board of Trustees shall be entirely responsible for the annual convention.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. *Composition.* The House of Delegates shall consist of (1) delegates elected by the component societies; (2) the officers of the Society; (3) the past presidents; (4) both general officers and members of the House of Delegates of the American Medical Association from the Illinois State Medical Society. Past Trustees shall be members of the House of Delegates without the right to vote.

Section 2. *Meetings.* The House of Delegates shall meet at the time and place of the annual convention of the Society, and shall fix its hours of meeting so that they shall not conflict with the general scientific meetings of the Society. If the interests of the Society and the profession require, the House of Delegates may meet in advance of the general scientific meetings.

Section 3. *Quorum.* Fifty delegates representing not less than twenty component societies shall constitute a quorum for the transaction of business.

Section 4. *Special Meetings.* Special meetings of the House of Delegates may be called by the president or a majority of the Board of Trustees, or shall be called on petition of twenty component societies.

When a special meeting is thus called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 5. *Delegates.* Each component society shall be entitled to send to the House of Delegates each year, one delegate for each 75 members, and one for a major fraction thereof; but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws, shall be entitled to one delegate.

The number of delegates to which any component society is entitled shall be determined by the number of active members of the component society on the membership rolls of the Illinois State Medical Society as of December 31 of the preceding year.

The term of office of a delegate shall begin January 1, and shall be for two years, or until his successor has been elected. Component societies with one delegate only, may elect for one year.

Section 6. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the

president and/or the secretary of the component society, stating that the delegate or alternate has been regularly elected to the House of Delegates.

A delegate or his alternate may be seated without credentials, provided he is properly identified by his county society and so certified to the secretary of the Illinois State Medical Society.

When a delegate and his alternate are unable to attend a specified meeting, the appropriate authorities of the component society concerned may appoint a substitute delegate and a substitute alternate who on presenting proper credentials, shall be eligible to regular membership in the House of Delegates.

A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until final adjournment of that meeting. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by that Committee. After the alternate has been seated, he cannot be replaced.

Section 7. *AMA Delegates and Alternate Delegates.* The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 8. *District Divisions.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Committees.* The House of Delegates shall have authority to designate to serve on ad hoc committees, members of the Society who are not members of the House and who may be present to participate in the debate on their reports.

Section 10. *Memorials and Resolutions.* It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, sixteen trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote. The majority of votes cast shall be necessary to elect.

The election of officers, members of standing committees, delegates and alternate delegates to the American Medical Association, shall be the first order of business at the last session of the House of Delegates. Officers of the Society shall assume office at the adjournment of the annual business meeting.

Section 3. *Terms of Office.* The president-elect, vice presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years.

The speaker and vice speaker shall not be elected for more than three consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become a trustee-at-large for a term of one year.

CHAPTER V. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

The president shall appoint the ad hoc committees of the House of Delegates. He may seek the advice of the officers and trustees.

He shall preside at the general scientific meetings of the Society or designate one of the vice presidents to substitute for him.

Section 2. *Successor to President.* In the event of the president's death, resignation, or removal from office, the first vice president shall succeed to the presidency.

Section 3. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 4. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint the reference committees.

He shall be an ex-officio member of the Committee on Constitution and Bylaws.

Section 5. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death, resignation or inability of the speaker to perform his duties, the

vice-speaker shall serve during the unexpired term.

Section 6. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these By-laws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom, owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

The secretary-treasurer shall give bond in such sum as may be fixed by the Board of Trustees, the premium on such bond to be paid by the Society. He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

CHAPTER VI. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of sixteen trustees elected by the House of Delegates [six shall be chosen from district number three, and one from each of the other ten districts (see map attached), these districts of the geographical area as of May, 1946], and one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect and secretary-treasurer.

The vice presidents, the speaker and vice speaker shall attend the meetings (including executive sessions), with the right of discussion, but without the right to vote.

Section 2. The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees

and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursements of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board shall also employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

C. *Committees.* The Board shall form the following committees within itself:

- (1) Executive Committee.
- (2) Finance Committee.
- (3) Policy Committee.
- (4) Such other committees as are deemed necessary.

D. *Duties of the Committees.*

- (1) *Executive Committee.* The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer and the trustee-at-large.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

- (2) *Finance Committee.* The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.
- (3) *Policy Committee.* The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society.

Section 6. *Quorum.* Ten members of the Board of Trustees shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publications.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of the district Ethical Relations Committee, Grievance Committee, and Prepayment Plans and Organizations Committee. He shall report to the Board of Trustees the actions of the component societies on reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report shall also specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Grievance Committee, a Committee on Prepayment Plans and Organizations, and such other committees as required to provide to each component society, those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected, subject to the general rules on composition of committees contained in Section 5, Chapter IX, of these Bylaws, at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER VIII. DUES AND EXPENSES

Section 1. *Annual Dues.* Assessments may be levied by the House of Delegates on each component society on a proportional basis. The amount of the dues shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association.

These annual dues shall include the annual subscription to the Illinois Medical Journal which shall be at least fifty per cent of the regular subscription price of the Journal.

Section 2. The Board of Trustees upon recommendation of the component society, shall give 50% reduction in dues to teaching, research and administrative personnel in full time employment in the approved medical schools in Illinois, or similar not-for-profit institutions in Illinois.

Section 3. Physicians in private practice of medicine may be given a 50% reduction in dues during

the first year of practice upon recommendation of their component society.

Section 4. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year.

Section 5. The Board of Trustees may authorize the remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association.

CHAPTER IX. COMMITTEES

Section 1. *Committee Meetings.* The chairman of a committee, when he considers it expedient and with the consent of two-thirds of the members of the committee, may conduct business or hold meetings by mail or by conference call, provided all members of the committee are given opportunity to participate, that minutes of the transactions are recorded, approved by the members participating, and circulated among all committee members.

Section 2. *Standing Committees.* The Standing Committees shall be:

A. Elected by the House of Delegates:

- A Committee on Medical Education
- A Grievance Committee
- A Committee on Prepayment Plans and Organizations
- A Committee on Disaster Medical Care
- A Committee on Laboratory Evaluation
- A Committee on Occupational Health
- A Committee on Public Safety

B. Appointed by the Board of Trustees:

- A Committee on Scientific Assembly
- A Medical Legal Committee
- A Committee on Impartial Medical Testimony
- A Committee on Legislation
- A Committee on Public Relations
- A Committee on Medical Benevolence
- A Committee on Archives
- A Committee on Constitution and Bylaws

Section 3. *Ad Hoc Committees.* The president or the Board of Trustees, each independently or at the discretion of the House of Delegates, or the House of Delegates independently, may appoint to accomplish specific tasks, committees which shall continue until the purpose for which they were appointed is accomplished, or until discharged by the appointing authority.

Section 4. *Other Committees.* Such other committees as shall be required to further the purposes for which the Illinois State Medical Society was founded, to implement directives and policies of the House of Delegates, or to act in liaison with other agencies, may be appointed by the president or the chairman of the Board of Trustees to serve

for the duration of the term of office of the appointing authority.

Section 5. *Composition.*

- A. Committees shall consist of at least three and not more than nine members.
- B. Members of standing committees shall serve for a term of three years except that
 - (1) when a vacancy occurs for any reason, it shall be filled for the unexpired term only, and
 - (2) when a committee is originally constituted, terms of committee members shall be staggered so that approximately one-third of the terms shall expire each year.
- C. The chairmen of standing committees elected by the House of Delegates shall be appointed annually by the president from the committee members. The chairmen of standing committees from the Board of Trustees shall be appointed annually by the chairman of the Board from the committee members.
- D. No member may serve on any committee for more than three consecutive terms or nine consecutive years.

Section 6. *Organization.* The power is vested in the authority electing or appointing a committee

- A. to create, organize and implement that committee;
- B. to enlarge it, or
- C. to abolish it without consideration of the unexpired terms of any of its members.

Section 7. *Vacancies.* Vacancies occurring for any reason in the membership of any committee may be filled for the unexpired term by appointment by the chairman of the Board of Trustees with the approval of the Board.

Section 8. *Ex-officio Members.* The president of the Society, chairman of the Board of Trustees and the secretary-treasurer of the Society shall be ex-officio members without the right to vote, of all committees.

Section 9. *Reports.* Annual reports shall be submitted to the House of Delegates by all committees.

Any committee shall report to the Board of Trustees when requested by the Board to do so.

Section 10. *Committee on Medical Education.* The Committee on Medical Education shall consist of five members to be elected by the House of Delegates.

This committee shall

- A. maintain a continuing interest in the recruitment of students, in the curricula of the medical schools and in postgraduate in-hospital training programs;
- B. carry to the deans of the medical schools recommendations from the viewpoint of the practicing physician;
- C. encourage and implement the AMA-ERF program in Illinois;

D. study, evaluate and criticize the postgraduate programs of the Illinois State Medical Society and other organizations, and

E. be available to advise and cooperate with the Department of Registration and Education of the State of Illinois.

Section 11. *Grievance Committee.* The Grievance Committee shall consist of six members elected by the House of Delegates.

Each component society should elect or appoint a grievance committee. If a county does not have a grievance committee, the district grievance committee shall function in its stead. The county or district grievance committee shall investigate complaints, and resolve differences arising from the rendering of professional services by members of the Society to the public.

Where the county or district grievance committee finds that factors in any case warrant, it shall recommend to the county medical society that charges of unethical conduct be preferred against the offending member of the Society. Failure to appear on order of the committee may be interpreted as grounds for a citation of unprofessional conduct.

It shall be the function of the State Society Grievance Committee

- A. to cooperate with grievance committees of component societies and districts in an effort to resolve differences between members of the Society and the public;
- B. to review the actions and decisions of county and district grievance committees when a party to a grievance complaint appeals from the decision of the local committee. Appeal to this committee is the privilege of such parties and they shall be so notified at the time of the hearing of the original complaint, and
- C. to conduct a continuing study of the complaints against the medical profession of the State of Illinois and to make recommendations to improve the quality of medical care.

To accomplish these purposes, the State Grievance Committee shall require that county medical societies furnish an annual report of their grievance committee activities including specifically

- A. the number of complaints
- B. a classification of the complaints
- C. the date of each complaint, and
- D. the date and nature of its settlement.

The Grievance Committee shall tabulate and analyze this material in its annual report to the House of Delegates.

Section 12. *Committee on Prepayment Plans and Organizations.* The Committee on Prepayment Plans and Organization shall consist of five members elected by the House of Delegates.

It shall review and adjust differences between members of the Society and prepayment plans and/or insurance organizations (including federal and

state governmental programs), except those otherwise served by special advisory committees. In disputes brought by third parties against physicians, the committee shall act only upon referral or appeal from county or district committees.

The committee shall encourage county medical societies to establish appropriate committees to which third party grievances may be brought and to notify third party plan administrators of the existence of such local committees.

The committee may

- A. recommended procedures for conducting hearings by county or district committees, and
- B. develop guides consistent with the policy of the House of Delegates for county medical societies in their dealings with third party plans which pay "usual and customary fees."

In any dispute over fees between a physician and any third party plan involving a fee or benefit schedule negotiated by the Illinois State Medical Society, the committee may act in review at the member's request without referral from the county or district committee.

The committee shall consider

- A. all problems bearing on the relationship between physicians and prepayment plans or health insurance carriers;
- B. methods for increasing the effectiveness of existing prepayment and insurance plans;
- C. proposals for the financing of medical care for all segments of the population, and
- D. problems encountered by physicians in supplying services under the various certificates and policies, or in the reporting of claims.

After being notified of the decision of the committee, a member of the Society shall have 30 days to appeal for a rehearing before the committee. If after careful investigation, the Committee on Prepayment Plans and Organizations finds that the complaint cannot be adjudicated amicably, the committee shall report the matter to the county society. If factors in the case warrant it, the committee may recommend that charges of unethical conduct be preferred against the offending member or that agreements with plans and organizations be re-evaluated.

Failure to appear on order of the committee may be grounds for citation of unprofessional conduct to the county society.

Section 13. *Committee on Disaster Medical Care.* The Committee on Disaster Medical Care shall consist of five members elected by the House of Delegates.

The committee shall:

- A. be responsible for assisting in the education of the profession and the public on the development and implementation of programs to provide medical care in the event of disaster;

- B. be responsible for directing the Society's efforts toward preparedness in the event of natural or man-made catastrophes;
- C. cooperate with civil defense agencies, public health departments, hospitals, management and labor organizations, paramedical groups and other agencies to establish unity and coordination, and
- D. serve in an advisory capacity to county medical societies in medical self-help training programs and hospital disaster planning.

Section 14. *Committee on Laboratory Evaluation.* The Committee on Laboratory Evaluation shall consist of five members elected by the House of Delegates.

The committee shall:

- A. effect methods of elevating and maintaining the standards of medical laboratories in Illinois;
- B. encourage the use of medical diagnostic laboratories supervised by duly qualified physicians, and
- C. encourage each county and district to establish evaluation committees.

Section 15. *Committee on Occupational Health.* The Committee on Occupational Health shall consist of five members elected by the House of Delegates.

The committee shall:

- A. be concerned with diseases and problems associated with occupational and industrial health;
- B. co-operate with the Council on Occupational Health of the American Medical Association, Industrial Medical Association and similar state agencies, and
- C. recommend to the State of Illinois Workman's Compensation Board medical procedures designed to assist the Board in the evaluation of claims.

Section 16. *Committee on Public Safety.* The Committee on Public Safety shall consist of five members elected by the House of Delegates.

The committee shall:

- A. study the medical aspects of accident prevention;
- B. alert the public to seasonal health hazards, and
- C. co-operate with the Illinois Department of Public Health, the National Safety Council and similar organizations.

Section 17. *Committee on Scientific Assembly.* The Committee on Scientific Assembly shall consist of nine members appointed by the Board of Trustees.

This committee

- A. shall coordinate the programs for the general assemblies, the section meetings and the scientific exhibits at the annual convention;
- B. shall appoint, with the approval of the Board, a secret committee to make awards to the scientific exhibitors;

- C. may incorporate in the annual scientific meetings those meetings of medical specialty groups which wish to affiliate with the Illinois State Medical Society annual convention, and
- D. shall arrange for the annual banquet and other social functions held during the annual convention.

Section 18. *Medical Legal Committee.* The Medical Legal Committee shall consist of five members appointed by the Board of Trustees.

It shall

- A. educate the members of the medical profession in medico-legal affairs, and
- B. cooperate with the American Medical Association in its program in the same fields.

It shall evaluate medical testimony given by physicians in the courts of Illinois. When questions on the validity of testimony arise, it shall have the authority

- A. to examine any member of the Illinois State Medical Society who is either suspected of or has been accused of giving improper testimony in any court proceedings
- B. to procure and examine transcripts of court testimony to determine whether or not fraudulent testimony has been given, and
- C. to report its findings to the Board of Trustees.

Where irregularities are found, the Board of Trustees may submit the findings to the Ethical Relations Committee of the county medical society for action.

It shall appoint a sub-committee to act in liaison with members of a similar committee of the Illinois Bar Association in matters involving both professions.

Section 19. *Impartial Medical Testimony Committee.* The Impartial Medical Testimony Committee shall consist of nine members appointed by the Board of Trustees.

It shall cooperate with the judiciary in both federal and state courts within the State of Illinois.

It shall, when requested by the court, implement the Impartial Medical Testimony Rule.

Section 20. *Committee on Legislation.* The Committee on Legislation shall consist of five members appointed by the Board of Trustees.

The Committee on Legislation shall represent and direct legislative activities of the Illinois State Medical Society in accordance with policies of the House of Delegates and at the direction of the Board of Trustees.

Committees and representatives of the Society which may be concerned with legislation shall, between meetings of the House of Delegates, channel their recommendations to the Board of Trustees for referral to the Committee on Legislation.

This committee shall

- A. inform the membership through approved media of all legislative matters of interest to the medical profession in the State of Illinois;
- B. maintain surveillance of all bills introduced

in the state legislature which have direct or indirect effect upon the practice of medicine or the state of health of the citizens of Illinois;

- C. maintain effective liaison with the American Medical Association Council on Legislative Activities and the American Medical Association Washington Office, so that members of the Illinois State Medical Society will be fully informed and can act vigorously on matters of federal legislation, and

- D. recommend to the Board of Trustees a legislative program for promulgation among the members of the Society.

A report of its activities shall be submitted currently to the Board of Trustees and annually to the House of Delegates.

Section 21. *Committee on Public Relations.* The Committee on Public Relations shall consist of five members appointed by the Board of Trustees.

It shall plan and execute programs designed to enhance the relationship between the public and the medical profession. It shall request the Board of Trustees to appoint sub-committees to accomplish specific purposes.

Section 22. *Committee on Medical Benevolence.* The Committee on Medical Benevolence shall consist of three members appointed by the Board of Trustees.

It shall

- A. examine applications to the Society for assistance to determine eligibility for benefits;
- B. keep the names of the beneficiaries confidential and known only to the committee, and
- C. recommend to the Finance Committee of the Board of Trustees the allotment for each recipient.

If funds available become inadequate to meet disbursement, the Finance Committee of the Board of Trustees shall be requested to appropriate sufficient funds to support the program until the next budget appropriation.

Section 23. *Committee on Archives.* The Committee on Archives shall consist of three members appointed by the Board of Trustees.

It shall

- A. assist in the collection and evaluation of medical items and records of historical interest to the Society and the public;
- B. cooperate with other associations and agencies to preserve and display such material;
- C. supervise the preparation of any written records of the Society or any of its activities, and
- D. inform the Board of Trustees of those special anniversaries which should be commemorated and shall supervise the observance of these occasions.

It shall appoint a sub-committee on the Museum of Medical History which shall

- A. be responsible for the establishment of a Museum of Medical Progress in the State of Illinois;
- B. cooperate with the historical museum of the State of Illinois and various other historical societies, and
- C. educate the public in the contributions made by physicians of Illinois to preventive medicine and the care and treatment of patients.

Section 24. *Constitution and Bylaws.* The Constitution and Bylaws Committee shall consist of five members appointed by the Board of Trustees.

It shall

- A. receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for the modification of the Constitution and/or Bylaws;
- B. prepare for the consideration of the House of Delegates all changes in the Constitution or Bylaws, and
- C. maintain constant surveillance of both documents to keep them current, effective and consistent with policies of the House of Delegates.

CHAPTER X. REFERENCE COMMITTEES

Section 1. *Appointment.* Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

Section 2. *Duties of Reference Committees.* References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

Section 3. *Organization.* Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 4. *Reference Committees.* The following committees are hereby provided for:

- A Committee on Credentials
- A Committee on Rules and Order of Business
- Tellers and Sergeants-at-Arms
- A Committee on Changes in the Constitution and Bylaws

- A Committee on Administrative Activities
- A Committee on Economic Activities
- A Committee on Scientific Activities
- A Committee on Public Relations Activities
- A Committee on Legislative Activities
- A Committee on Miscellaneous Business

Section 5. *The Committee on Credentials* shall consider all questions regarding the registration and the credentials of the delegates. It shall pass out and receive the attendance slips for each session of the House of Delegates, and perform any other duties assigned.

Section 6. *Committee on Rules and Order of Business* shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

Section 7. *The Tellers and Sergeants-at-Arms* shall serve the speaker of the House of Delegates whenever the situation arises which requires a ballot vote or executive session of the House of Delegates.

Section 8. *The Committee on Changes in Constitution and Bylaws* shall consider all proposed amendments to the Constitution and Bylaws.

The chairman of the Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee of the House of Delegates.

Section 9. *The Committee on Administrative Activities* shall consider the annual reports of the officers, trustees, the executive administrator and such other reports as pertain to the administrative activities of the Society.

Section 10. *The Committee on Economic Activities* shall consider the annual reports of those individuals and committees concerned with the socioeconomic field of medicine as assigned to that Division of the Society.

Section 11. *The Committee on Scientific Activities* shall consider the annual reports of the individuals and committees concerned with the editing and publishing of the Illinois Medical Journal, and also the various scientific activities as assigned to that Division of the Society.

Section 12. *The Committee on Public Relations Activities* shall consider the annual reports of those individuals and committees concerned with public relations as assigned to that Division of the Society.

Section 13. *Committee on Legislative Activities* shall consider the annual reports of the individuals and committees concerned with legislative and legal aspects as assigned to that Division of the Society.

Section 14. *Committee on Miscellaneous Business*

shall consider all other business not allocated to any of the enumerated committees, and any new business to come before the House of Delegates not otherwise provided for.

CHAPTER XI. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this Society before the first of February each year.

Section 10. Any component society which fails to pay its assessment or make the annual report required on or before April fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of April of the current year. Immediately after the first of April, each delinquent member shall be notified that in consequence of non-payment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be automatically dropped. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

CHAPTER XII. DISCIPLINE

Section 1. *Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review matters involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its

component societies, and charges of misconduct of members of the Society.

It shall serve as an appellate body to review cases involving these matters referred by component medical societies, and shall consider only matters of procedure.

Section 2. Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

- A. he has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or
- B. he has been adjudged guilty by his component society in accordance with the procedural requirements of these bylaws:

- (1) of a gross misconduct as a physician or surgeon, or
- (2) of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Procedure.* Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to prosecute formal charges. In the event the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

Section 4. Original complaints received by the Illinois State Medical Society should be referred directly to the secretary of the component society of which the accused is a member and to the appropriate district Ethical Relations Committee.

Section 5. The following principles of justice shall guide all disciplinary actions:

- A. An accused is presumed to be innocent until he has been proven guilty.
- B. After charges have been preferred there shall be no evasion of the fact that the respondent is to be tried; that the Ethical Relations Committee before which he is cited to appear is a trial body, and that he will be on trial when he appears.
- C. He must be notified by registered mail of the specific charges which are made against him at least ten days before the date set for his trial.
- D. He may not be found guilty of anything not included in the charges preferred against him and presented to him.
- E. All evidence not pertinent to the charge as made shall be considered irrelevant and immaterial. It shall be wholly disregarded in the decision.
- F. Testimony not bearing on the charges shall be objected to, and if sustained by the trial body, stricken from the records.

G. The respondent shall be advised of his rights by the trial body, namely: (1) that he may be represented by any member of the Society as counsel; (2) that he or his counsel may cross examine witnesses; (3) that he may offer in evidence any records or documents that he deems fit; (4) that he may enter objections as to testimony or to material offered in evidence; (5) that he may address the trial body in his own behalf; (6) and that he has the right of appeal to the Board of Trustees of the Illinois State Medical Society.

Section 6. A comprehensive stenographic record of the proceedings must be kept for reference, and shall be available until final adjudication has been made.

Section 7. This committee, sitting as a trial body, shall find the accused either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension or expulsion.

The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by registered mail at least ten days before the date set for the meeting at which this action will be taken.

If the findings of the trial body are against the accused the secretary of the component society shall acquaint the accused by registered mail with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

Section 8. Appeals received by the Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. The committee shall notify the accused and the secretary of the component society by registered mail at least ten days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with rules established by the Board of Trustees.

Section 9. On conclusion of the hearing, the Ethical Relations Committee of the Board of Trustees shall meet in executive session to consider its decision, and shall report in writing to the Board at its next meeting for final action.

Section 10. In case of findings against the accused, the secretary of the Society shall notify the accused within ten days by registered mail of his right to appeal to the Judicial Council of the American Medical Association.

Section 11. The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant held membership, of the action of the Board.

Section 12. In the event of a decision by the Board of Trustees of improper procedure of trial or findings, the case shall be remanded to the component society for reconsideration.

CHAPTER XIII. MISCELLANEOUS

Section 1. The fiscal year of this Society shall be from January 1 to December 31 inclusive.

Section 2. Robert's "Rules of Order, Revised," shall be the guide for all procedure when not in conflict with the Consitution and Bylaws.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

ORDER OF BUSINESS OF THE HOUSE OF DELEGATES

First Session

- (1) Call to order.
- (2) Report of Committee on Credentials.
- (3) Roll Call.
- (4) Reading and approval of minutes of last meeting.
- (5) Appointment of Reference Committees.
- (6) Reports of Officers.
- (7) Reports of the Trustees, the Editor, etc.
- (8) Reports of Standing Committees.
- (9) Reports of Board Committees.
- (10) Reports of Special Committees.
- (11) Reading of Resolutions.
- (12) Unfinished Business.
- (13) New Business.
- (14) Recess.

Last Session

- (1) Call to order.
- (2) Report of Committee on Credentials.
- (3) Roll Call.
- (4) Election of Officers.
- (5) Election of Trustees.
- (6) Election of Delegates to the American Medical Association.
- (7) Election of Alternate Delegates to the American Medical Association.
- (8) Election of Standing Committees.
- (9) Fixing per capita tax for ensuing year.
- (10) Selection of meeting place for next annual meeting. (Subject to the investigations of the Board.)
- (11) Reports of Reference Committees.
- (12) Unfinished Business.
- (13) Induction of the President-Elect to the office of President.
- (14) New Business.
- (15) Adjournment.

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HOUSE OF DELEGATES

1965-1966 OFFICERS

Officers

President, Burtis E. Montgomery, Harrisburg
President-Elect, Caesar Portes, 25 E. Washington St., Chicago
1st Vice President, Michael R. Saxon, Oswego
2nd Vice President, Casper Epsteen, 25 E. Washington St., Chicago
Secretary-Treasurer, Jacob E. Reisch, 1129 S. 2nd St., Springfield
Speaker, Edward W. Cannady, 4601 State St., East St. Louis
Vice Speaker, Maurice M. Hoeltgen, 1836 W. 87th St., Chicago

Board of Trustees

1st District—Carl E. Clark, Sycamore.....1968
2nd District—Ralph N. Redmond, 101 E. Miller Rd., Sterling1968
3rd District—William M. Lees, 7000 N. Kenton Ave., Lincolnwood.....1968
Frank J. Jirka, 1507 Keystone Ave., River Forest1968
Philip Thomsen, 13828 Lincoln Ave., Dolton.1966
J. Ernest Breed, 55 E. Washington St., Chicago1966
William E. Adams, 950 E. 59th St., Chicago1967
Ted LeBoy, 330 Gale Ave., River Forest...1967
4th District—Paul P. Youngberg, 1520 Seventh Ave., Moline1967
5th District—Darrell H. Trumpe, St. John's Sanatorium, Springfield1967
6th District—Newton DuPuy, 1101 Maine St., Quiney1966
7th District—Arthur F. Goodyear, 142 E. Prairie Ave., Decatur.....1967
8th District—Wm. H. Schowengerdt, 301 E. University Ave., Champaign.....1967
9th District—Charles K. Wells, 117 N. 10th St., Mt. Vernon1966
10th District—Willard C. Scrivner, 4601 State St., East St. Louis.....1966
11th District—Joseph R. O'Donnell, 444 Park Ave., Glen Ellyn1968

TRUSTEE-AT-LARGE, Edward A. Piszczek, 6410 N. Leona Ave., Chicago

CHAIRMAN OF THE BOARD, William E. Adams, 950 East 59th St., Chicago

Past Presidents

Robert S. Berghoff1948
Everett P. Coleman.....1945-1946
Rolland L. Green.....1937
Edwin S. Hamilton.....1962
Harry M. Hedge.....1951
H. Close Hesseltine.....1961
Percy E. Hopkins.....1949
James H. Hutton.....1940
Willis I. Lewis.....1954
George F. Lull1963
Irving H. Neece.....1948
Raleigh C. Oldfield.....1959
Leo P. A. Sweeney.....1953
Arkell M. Vaughn.....1955
C. Paul White.....1952

Officers of the American Medical Association

Percy E. Hopkins (Past President)
Chairman—Board of Trustees, AMA
Walter C. Bornemeier (AMA Delegate)
Vice-Speaker—House of Delegates, AMA

Executive Committee

William E. Adams, *Chairman*
(*Chairman of the Board*)
Burtis E. Montgomery, *President*
Caesar Portes, *President-Elect*
Jacob E. Reisch, *Secretary-Treasurer*
Edward A. Piszczek, *Trustee-at-Large*
Carl E. Clark, *Chairman, Finance Committee*
Newton DuPuy, *Chairman, Policy Committee*
EX-OFFICIO: Edward W. Cannady,
Speaker, House of Delegates
STAFF: Robert L. Richards

Finance Committee

Carl E. Clark, *Chairman*
Jacob E. Reisch, *Secretary-Treasurer*
Ralph N. Redmond
Philip Thomsen
STAFF: Robert L. Richards

(See addenda page 263)

DOWNSTATE DELEGATES AND ALTERNATES

<i>Delegate</i>	<i>Alternate</i>	<i>Delegate</i>	<i>Alternate</i>
ADAMS		FRANKLIN	
Richard Cooper	Harold Swanberg	John P. Pope	Harry L. Lewis
ALEXANDER		FULTON	
James L. Crouse		Keith H. Frankhauser	P. D. Reinertsen
BOND		GALLATIN	
Boyd E. McCracken	Max Fraenkel	John E. Doyle	W. F. Stanelle
BOONE		GREENE	
John H. Steinkamp	M. Paul Dommers	Paul A. Dailey	A. K. Baldwin
BUREAU		HANCOCK	
K. M. Nelson	G. E. Giffin	C. W. Bruehsel	Byron I. Mueller
CARROLL		HENDERSON	
Eliseo M. Colli	L. B. Hussey	Silvino Lindo	Elmer Swann
CASS-BROWN		HENRY	
B. A. DeSulis	James J. Hea	Paul M. Schmidt	Wm. D. Larson
CHAMPAIGN		IROQUOIS	
1. Carl Greenstein	H. J. Kolb	R. Kent Swedlund	James Dailey
2. C. H. Walton	R. E. Schaede	JACKSON	
CHRISTIAN		J. A. Petrazio	Martin H. Powell, Jr.
C. D. Brummitt	Ralph M. Seaton	JASPER	
CLARK		Don L. Hartrich	C. O. Absher
Eugene P. Johnson	Geo. T. Mitchell	JEFFERSON-HAMILTON	
CLAY		Herman Rogers	A. W. Anderson
Wm. T. Kamp	H. T. Fehrenbacker	JERSEY	
CLINTON		Bernard Baalman	H. E. Wuestenfeld
M. A. Bateman	Wilson L. DuComb	JoDAVISS	
COLES-CUMBERLAND		J. Eric Gustafson	A. L. Hildinger
Joseph R. Mallory	Mack W. Hollowell	JOHNSON	
CRAWFORD		E. A. Veach	W. J. Wakefield
Charles N. Salesman	Raymond B. Murphy	KANE	
DEKALB		1. John A. Newkirk	D. M. Schleifer
T. P. deGraffenried	J. W. Ovitz, Jr.	2. Wayne N. Leimbach	Wm. H. Donovan
DEWITT		3. B. F. Shirer	J. L. Bordenave
Herman L. Meltzer	Charles A. Ramey	KANKAKEE	
DOUGLAS		Donald A. Meier	Dale M. Learned
E. J. Gross	Myron Boylson	KENDALL	
DUPAGE		Michael R. Saxon	Ray Crawford
1. James P. Campbell	Frederick C. Kuharich	KNOX	
2. Morgan M. Meyer	Arthur P. LeBean	J. A. Bowman	Fred Stansbury
3. Joseph R. O'Donnell	Chas. B. VanGorder	LAKE	
4. J. P. Schweitzer	B. L. Rodkinson	1. George B. Callahan	Charles Culmer
EDGAR		2. Donald Nellins	Walter J. Reedy
Jerry M. Ingalls	James H. Acklin	3. Earl V. Klaren	M. J. McAndrew
EDWARDS		LaSALLE	
Charles P. Salisbury	Andrew Krajec	William A. Scanlon	J. B. Aplington
EFFINGHAM		LAWRENCE	
Wm. S. Vanbergen	James R. Gartner	Tom Kirkwood	R. T. Kirkwood
FAYETTE		LEE	
Stanley W. Moore	Hans Rollinger	Wm. A. McNichols	Charles H. LeSage
FORD		LIVINGSTON	
Paul W. Sunderland	Ross N. Hutchison	Don E. Ervin	George T. Crout

<i>Delegate</i>	<i>Alternate</i>	<i>Delegate</i>	<i>Alternate</i>
LOGAN Charles R. Bardwell	Glen Tomlinson	RICHLAND Wm. A. Moore	Wayne Moulton
McDONOUGH V. B. Adams	Donald Dexter	ROCK ISLAND 1. J. G. Gustafson 2. Theodore Grevas	H. T. Kutsunis Raymond W. Dasso
McHENRY M. Mijanovich	A. Mijanovich	ST. CLAIR 1. Wm. H. Walton 2. V. P. Siegel	Lloyd F. Walk Harold McCann
McLEAN A. Edward Livingston		SALINE N. A. Thompson	D. A. Lehman
MACON 1. Maurice D. Murfin 2. C. Elliott Bell	Hyman J. Burstein C. F. Downing	SANGAMON 1. Preston V. Dilts 2. Chauncey C. Maher, Jr.	Ross Schlich Richard F. Herndon
MACOUPIN Joseph J. Grandone	Roger Quinn	SCHUYLER Henry C. Zingher	
MADISON 1. Eugene F. Moore 2. Edward K. DuVivier	Julius Katz J. Mather Pfeiffenberger	SHELBY Duncan Biddlecombe	H. H. Pettry
MARION Karl D. Venters	Karl Venters	STEPHENSON Thomas A. Haymond	H. R. Osheroff
MASON J. W. McHarry	H. W. Maxfield	TAZEWELL Roger Neumann	Robert L. Tucker
MASSAC George Green	Virgil O. Decker	UNION William H. Whiting	John Pfau
MENARD Robert J. Schafer	Paul L. Purdy	VERMILION G. L. Seitzinger	Edwin G. Andracki
MERCER M. E. Conway	John E. Bohan	WABASH William L. Walling	Don Risley
MONROE Russell W. Jost	Joseph Werth	WARREN Kenneth E. Ambrose	Russell M. Jensen
MONTGOMERY George A. Telfer	James D. Telfer	WASHINGTON Walter P. Plassman	William P. Lesko
MORGAN Albert F. Fricke	E. C. Bone	WAYNE C. J. Jannings	E. S. Talaga
MOULTRIE Eugene J. Boros	Fred Yamamoto	WHITE S. B. Abelson	D. R. Hansard
OGLE Russel W. Zack	Arthur R. Bogue	WHITESIDE C. J. Mueller	Isaac Vandermyde
PEORIA 1. Wm. O. McQuiston 2. Norman Powers 3. F. A. Christensen	Wm. F. Chambers S. M. Scalzo George J. Best	WILL-GRUNDY 1. Lloyd Jessen 2. Leonard F. Roblee	George Woodruff Robert J. Becker
PERRY C. E. Cawvey	James B. Stotlar	WILLIAMSON Herbert Fine	Richard Fox
PIATT Edgar W. Weir	W. E. Mundt	WINNEBAGO 1. Paul A. VanPernis 2. Harold E. Zenisek 3. F. A. Munsey	L. P. Johnson A. R. K. Matthews Harry E. LaPlante
PIKE-CALHOUN James H. Rutledge	James E. Goodman	WOODFORD Robert Lykkebak	Joseph C. Phifer
PULASKI James G. Conger	A. L. Robinson		
RANDOLPH Rob't. E. Schettler	O. W. Pfasterer		

CHICAGO MEDICAL SOCIETY DELEGATES

<i>Delegate</i>	<i>Alternate</i>	<i>Delegate</i>	<i>Alternate</i>
AUX PLAINES BRANCH		NORTH SIDE BRANCH	
Joseph C. Sodaro	William F. Ashley	Michael Boley	Coye C. Mason
Clair M. Carey	Craig D. Butler	Roland R. Cross	R. Gilchrist
John S. Hyde	Robert F. Sharer	Samuel L. Andelman	Samuel A. Levinson
C. Otis Smith	Everett E. Nicholas	William Hutehison	Bernard Peele
Herbert Ratner	James B. Hartney	Anton Pantone	Marvin Rosner
Charles J. Weigel	Michael J. Parenti	Vincent Freda	Harold Lasky
Arthur E. Joslyn	A. Everett Joslyn, Jr.	Jack Williams	Benjamin Lounsbury
A. G. Lawrence	Roland Kowal	Erwin M. Patlak	Gustav Kaufmann
		Clifton L. Reeder	Steven Barron
		John P. Malia	Jas. P. FitzGibbons
CALUMET BRANCH		NORTH SUBURBAN BRANCH	
Donald Farmer	Edward Coreoran	Robert A. Snyder	David R. Barnum
Stanley Ruzich	Harry Weisberg	Harold C. Lueth	Howard C. Burkhead
Thaddeus Fial	Eugene F. Diamond	C. Malcolm Rice, Jr.	James W. Ford
		John L. Savage	Donald E. Hansen
DOUGLAS PARK BRANCH		William Harridge	William FitzPatrick
Edward A. Razim	Otto Koluvek, Jr.	Arnold Wagner	Stanley E. Huff
L. S. Tichy	Robert F. Cesafsky	William Cummings	Robert P. Cutler
Colman J. O'Neill	Paul Zettas	Noel G. Shaw	Frank Pirruccello
John D. McCarthy	Gilbert R. DeMange	Raymond H. Conley	Jerome T. Paul
Raymond Nemecek	Miles Cermak		
ENGLEWOOD BRANCH		NORTHWEST BRANCH	
Marcello Gino	Samuel L. Hamilton	N. J. Kupferberg	Louis A. Wajay
Edward J. Krol	John R. Krolikowski	M. J. Kutza	M. A. Rydelski
Frank C. Kwinn	John E. Meyer	A. J. Linowiecki	*James M. McDonnough
Frank J. Saletta	Joseph A. Patka	F. M. Nicholson	L. S. Sluzynski
Francis W. Young	Geo. J. Rukstinat	Peter N. Furno	R. V. Kochanski
		S. N. Goldberger	Alfred A. Zanette
IRVING PARK BRANCH			*deceased
L. F. Mammoser	George Pastnack	SOUTH CHICAGO BRANCH	
Arthur T. Haebich	F. J. Haufe	Tibor Czeisler	Morris Friedell
T. J. Conley	Alfred Faber	M. E. Finsky	John M. Coleman
George W. Holmes	Arnold U. Derman	Simon J. Saltman	John J. Marlow
Fred A. Tworoger	S. A. Franzblau	Arthur W. Fleming	Albert L. Pisani
David O. Dale	Eugene T. Broccolo		
Eugene M. Narsette	H. Paul Carstens	SOUTH SIDE BRANCH	
Alexander N. Ruggie	Allen Hrejsa	Quentin Young	Jacob Epstein
JACKSON PARK BRANCH		Robert R. Mustell	Maurice Gleason
Wright Adams	Julius Ginsberg	SOUTHERN COOK COUNTY BRANCH	
Andrew J. Brislen	Chester Guy	Cyril Gallati	Gerard Gnade
William J. Hand	Henrietta Herbolsheimer	Frederick Weiss	John Koenig
David S. Fox	Harry L. Hunter	Howard W. Schneider	Leonard Lewis
Frank E. Maple	Daniel J. Pachman		
Charles P. McCartney		STOCK YARDS BRANCH	
NORTH SHORE BRANCH		Glenn A. Burekart	Frank J. Nowak
George H. Irwin	T. A. Davis	E. J. Lukaszewski	Joseph M. Ruda
Burton Soboroff	Herschel Browns		
C. A. Norberg	Joseph Skom	WEST SIDE BRANCH	
Chester L. Crean	Willis J. Diffenbaugh	George Kaiser	Engene T. Hoban
Philip R. McGuire	Robert Jensik	Anna Marcus	George Rezek
Edward C. Helfers	Eugene J. Ranke	Joseph F. O'Malley	Louis S. Varzino
W. B. Stromberg, Sr.	John B. Murphy		
Karl L. Vehe	Samuel T. Gerber	AT-LARGE	
Joseph R. DeCaro	Frank M. Quinn	Theo R. VanDellen	A. L. Burdick, Sr.
W. O. Ackley	David T. Petty	Casper Epstein	Harold A. Sofield
Philip M. Bedessem	Geo. C. Markoutsas		

DELEGATES AND ALTERNATES TO A.M.A.

(To take office Jan. 1, 1964—

Term expires Dec. 31, 1965)

Elected on May 16, 1963

H. Kenneth Sealiff, 4753 Broadway, Chicago
George F. Lull, 400 E. Randolph St., Chicago
Walter C. Bornemeier, 4665 Peterson Ave., Chicago
George C. Turner, 670 N. Michigan Ave., Chicago
Frank H. Fowler, 6356 Diversey Ave., Chicago
Edward A. Piszczek, 6410 N. Leona Ave., Chicago
Arthur F. Goodyear, 142 E. Prairie St., Decatur
Newton DuPuy, 1101 Maine St., Quincy
Harlan English, 909 N. Logan Ave., Danville
Jacob E. Reisch, 1129 S. 2nd St., Springfield
E. W. Cannady, 4601 State St., East St. Louis
Carl E. Clark, Sycamore

(To take office Jan. 1, 1965—

Term expires Dec. 31, 1966)

Elected on May 21, 1964

Maurice M. Hoeltgen, 1836 W. 87th St., Chicago
Theodore R. VanDellen, 435 N. Michigan Ave., Chicago
Leo P. A. Sweeney, 10725 S. Western Ave., Chicago

Allison L. Burdick, Sr., 5906 W. North Ave., Chicago

H. Close Hesseltine, 5841 S. Maryland Ave., Chicago
Arnell M. Vaughn, 2015 E. 79th St., Chicago
William K. Ford, 303 N. Main St., Rockford
Paul A. Dailey, 620 N. Main St., Carrollton
Burtis E. Montgomery, Harrisburg
Fred C. Endres, 4609A Prospect Rd., Peoria Hts.

(To take office Jan. 1, 1966—

Term expires Dec. 31, 1967)

Elected on May 19, 1965

H. Kenneth Sealiff, 4753 Broadway, Chicago
Harold A. Sofield, 715 Lake St., Oak Park
Walter C. Bornemeier, 4665 Peterson Ave., Chicago
George C. Turner, 670 N. Michigan Ave., Chicago
Frank H. Fowler, 6356 Diversey Ave., Chicago
Edward A. Piszczek, 6410 N. Leona Ave., Chicago
Arthur F. Goodyear, 142 E. Prairie St., Decatur
Newton DuPuy, 1101 Maine St., Quincy
Harlan English, 909 N. Logan Ave., Danville
Jacob E. Reisch, 1129 S. 2nd St., Springfield
Edward W. Cannady, 4601 State St., East St. Louis
Carl E. Clark, Sycamore

OFFICERS OF COUNTY MEDICAL SOCIETIES---1965

ADAMS COUNTY

President: John H. Cravens, 1101 Maine St., Quincy
Secretary: G. H. Eversman, Jr., 2174 Maine St., Quincy
Members: 74—District #6—Annual Meeting: December

ALEXANDER COUNTY

President: Charles L. Yarbrough, 800 Commercial Ave., Cairo
Secretary: James L. Crouse, 1201 Washington, Cairo
Members: 10—District #10

BOND COUNTY

President: M. Kenneth Kaufmann, 207 N. 2nd St., Greenville
Secretary: Charles R. Daisy, 308 W. College Ave., Greenville
Members: 8—District #7

BOONE COUNTY

President: Stanley J. Smith, 601-1/2 S. State St., Belvidere
Secretary: Earl S. Davis, 119 S. State St., Belvidere
Members: 14—District #1—Annual Meeting: December

BUREAU COUNTY

President: Louis P. Lukancie, 207 E. St. Paul St., Spring Valley
Secretary: Earl Dexter Nelson, 101 Park Ave. East, Princeton
Members: 29—District #2

CARROLL COUNTY

President: C. G. Piper, 113-1/2 W. Market St., Mt. Carroll
Secretary: Karl H. Reddies, 333 Chicago Ave., Savanna
Members: 11—District #1—Annual Meeting: December

CASS-BROWN COUNTY

President: Robert A. Spencer, 115 W. 4th St., Beardstown
Secretary: Arthur G. Hyde, 507 Washington St., Beardstown
Members: 14—District #6

CHAMPAIGN COUNTY

President: Richard E. Dukes, 602 W. University Ave., Urbana
Secretary: H. Ewing Wachter, 104 W. Clark St., Champaign
Members: 159—District #8—Annual Meeting: November

CHICAGO MEDICAL SOCIETY

President: Noel G. Shaw, 310 S. Michigan Ave., Chicago
President-Elect: Warren W. Young, 310 S. Michigan Ave., Chicago
Secretary: Francis W. Young, 310 S. Michigan Ave., Chicago
Exec. Administrator: Mr. John W. Neal, 310 S. Michigan Ave., Chicago
Members: 6123—District #3—Annual Meeting: June

CHRISTIAN COUNTY

President: C. D. Brummitt, 715 Vine St.,
Taylorville
Secretary: Joseph W. Murphy, 301 S. Webster
Ave., Taylorville
Members: 29—District #7

CLARK COUNTY

President: Howard G. Johnson, 22 W. Main St.,
Casey
Secretary: Eugene P. Johnson, 22 W. Main St.,
Casey
Members: 7—District #8—Annual Meeting:
January

CLAY COUNTY

President: Meyer H. Parker, P. O. Box 98,
Louisville
Secretary: William T. Kamp, Flora Clinic, Flora
Members: 15—District #7—Annual Meeting:
January

CLINTON COUNTY

President: M. A. Bateman, Carlyle
Secretary: J. Roger Sosa, Germantown
Members: 10—District #7—Annual Meeting:
January

COLES-CUMBERLAND COUNTY

President: Guy O. Pfeiffer, Link Clinic, Mattoon
Secretary: Stanley W. Thiel, Link Clinic, Mattoon
Members: 43—District #8—Annual Meeting:
January

CRAWFORD COUNTY

President: Don Knapp, 1201 N. Allen St.,
Robinson
Secretary: John W. Long, Robinson
Members: 17—District #8—Annual Meeting:
December

DEKALB COUNTY

President: Robert Purdy, Shabbona
Secretary: Robert H. Pribble, DeVal Shopping
Ctr., DeKalb
Members: 49—District #1—Annual Meeting:
November

DEWITT COUNTY

President: John W. Veirs, 219 E. Main St.,
Clinton
Secretary: Charles Ramey, 215 E. Main St.,
Clinton
Members: 12—District #5—Annual Meeting:
January

DOUGLAS COUNTY

President: Myron Boylson, Tuscola
Secretary: Travis Hindman, Tuscola
Members: 15—District #8—Annual Meeting:
December

DUPAGE COUNTY

President: J. M. Stoker, 172 Schiller, Elmhurst
Secretary: Charles A. Lang, 222 E. Willow St.,
Wheaton
Executive Secretary: Mrs. Lillian Widmer, 222
E. Willow St., Wheaton
Members: 292—District #11—Annual Meeting:
December

EDGAR COUNTY

President: Gordon H. Sprague, 502 Shaw Ave.,
Paris
Secretary: Jerry M. Ingalls, 502 Shaw Ave.,
Paris
Members: 12—District #8—Annual Meeting:
March

EDWARDS COUNTY

President: C. P. Salisbury, 10 S. 4th St., Albion
Secretary: Andrew Krajee, Box 336, West Salem
Members: 4—District #9

EFFINGHAM COUNTY

President: William Van Bergen, 900 S. 1st St.,
Effingham
Secretary: D. G. Huelskoetter, Altamont
Members: 22—District #7

FAYETTE COUNTY

President: J. H. Weiner, 503 Gallatin, Vandalia
Secretary: E. A. Kuehn, 501-1/2 W. Gallatin,
Vandalia
Members: 12—District #7—Annual Meeting:
January

FORD COUNTY

President: Paul Sunderland, 214 N. Sangamon
St., Gibson City
Secretary: Alan Olson, 130 N. Center St., Paxton
Members: 11—District #11—Annual Meeting:
January

FRANKLIN COUNTY

President: Richard Johnson, Wood Bldg., Benton
Secretary: John Pope, Pope Bldg., Benton
Members: 22—District #9—Annual Meeting:
December

FULTON COUNTY

President: Joel P. Blancaflor, Lewistown
Secretary: O. M. Wood, Ipava
Members: 26—District #4—Annual Meeting:
January

GALLATIN COUNTY

President: John Doyle, Ridgway
Secretary: James A. Kirby, New Haven
Members: 4—District #9

GREENE COUNTY

President: Richard Jakobi, 108 E. Bridgeport,
White Hall
Secretary: Paul A. Dailey, 620 N. Main St.,
Carrollton
Members: 8—District #6—Annual Meeting:
December

HANCOCK COUNTY

President: Paul Breckner, Plymouth
 Secretary: Ilse E. Brueshel, Warsaw
 Members: 13—District #4—Annual Meeting:
 December

HENDERSON COUNTY

President: Elmer Swann, Oquawka
 Secretary: Harold Bock, Stronghurst
 Members: 3—District #4

HENRY COUNTY

President: William G. Neilson, 235-1/2 W. 2nd St.,
 Kewanee
 Secretary: A. W. Wellstein, 213 W. 1st St.,
 Geneseo
 Members: 35—District #4—Annual Meeting:
 November

IROQUOIS COUNTY

President: H. A. Braithwaite, Onarga
 Secretary: N. C. Afable, Clifton
 Members: 22—District #11—Annual Meeting:
 December

JACKSON COUNTY

President: Andrew R. Esposito, 106 S. 14th St.,
 Murphysboro
 Secretary: Donald R. Darling, 404 W. Main St.,
 Carbondale
 Members: 48—District #10—Annual Meeting:
 December

JASPER COUNTY

President: Don L. Hartrich, 625 N. Jourdan,
 Newton
 Secretary: C. O. Absher, Newton
 Members: 4—District #8

JEFFERSON-HAMILTON COUNTY

President: Charles K. Wells, 117 N. 10th St.,
 Mt. Vernon
 Secretary: Harry Goff Thompson, Jr., P. O. Box
 356, Mt. Vernon
 Members: 22—District #9—Annual Meeting:
 January

JERSEY-CALHOUN COUNTY

President: Henry K. Popielewski, Hardin
 Secretary: W. Clark Doak, 300 S. Washington
 St., Jerseyville
 Members: 10—District #6

JO DAVIESS COUNTY

President: Delbert O. Williams, Jr., Stockton
 Secretary: William G. Gillies, 300 Summit St.,
 Galena
 Members: 11—District #1—Annual Meeting:
 February

JOHNSON COUNTY

President: W. J. Wakefield, Vienna
 Secretary: E. A. Veach, Vienna
 Members: 3—District #9—Annual Meeting:
 January

KANE COUNTY

President: William G. Eilert, 410 Downer Place,
 Aurora
 Secretary: Robert Cummins, 17 N. 6th St.,
 Geneva
 Corresponding Secretary: Miss Elsa Carlson, 17
 N. 6th St., Geneva
 Members: 246—District #1—Annual Meeting:
 October

KANKAKEE COUNTY

President: Louis Ehrlich, 1309 E. Court St.,
 Kankakee
 Secretary: Herbert P. Swartz, 450 Kennedy
 Drive, Kankakee
 Members: 80—District #11

KENDALL COUNTY

President: Walter Brill, 20 W. Main St., Plano
 Secretary: Michael Saxon, Oswego
 Members: 9—District #11

KNOX COUNTY

President: Richard H. Bick, 369 N. Kellogg St.,
 Galesburg
 Secretary: John J. Holland, 511 Bondi Bldg.,
 Galesburg
 Members: 60—District #4—Annual Meeting:
 November

LAKE COUNTY

President: C. Russell Sugden, 763 Deerfield Rd.,
 Deerfield
 Secretary: John H. Schroeder, 1616 Grand Ave.,
 Waukegan
 Executive Secretary: Mrs. Howard N. Schulz,
 P. O. Box 148, Gurnee
 Members: 234—District #1—Annual Meeting:
 December

LA SALLE COUNTY

President: Deloss R. Hanley, 1221 Madison St.,
 Streator
 Secretary: J. N. Hackett, 208 S. Columbia Ave.,
 Oglesby
 Members: 106—District #2—Annual Meeting:
 November

LAWRENCE COUNTY

President: Charles G. Stoll, 802 Jefferson St.,
 Lawrenceville
 Secretary: E. A. Fahnestock, 627 Judy Ave.,
 Bridgeport
 Exec. Sec'y: Miss Ruth E. Gariepy, Lawrence
 County Memorial Hospital, Lawrenceville
 Members: 11—District #8—Annual Meeting:
 November

LEE COUNTY

President: Charles LeSage, 114 W. Everett,
 Dixon
 Secretary: Samuel Adler, 913 N. Ottawa Drive,
 Dixon
 Members: 21—District #2—Annual Meeting:
 January

LIVINGSTON COUNTY

President: Don L. Ervin, 604 N. Birch St.,
Fairbury
Secretary: George T. Crout, 200 N. Jackson St.,
Flanagan
Members: 30—District #2—Annual Meeting:
February

LOGAN COUNTY

President: James B. Borgerson, 111 S. Vine St.,
Mt. Pulaski
Secretary: Glen E. Tomlinson, 301 Walnut St.,
Lincoln
Members: 25—District #5—Annual Meeting:
December

MCDONOUGH COUNTY

President: Olin Dively, 221 W. Carroll, Macomb
Secretary: Frank DeRango, 531 E. Grant St.,
Macomb
Members: 21—District #4—Annual Meeting:
October

McHENRY COUNTY

President: Helmuth Stahlecker, 666 W. Jackson,
Woodstock
Secretary: Mladen Mijanovich, 555 E. Grant,
Marengo
Members: 60—District #1—Annual Meeting:
January

McLEAN COUNTY

President: G. Bradley McNeely, 429 N. Main St.,
Bloomington
Secretary: Preston Houk, 429 N. Main St.,
Bloomington
Executive Secretary: Mr. David W. Meister, 429
N. Main St., Bloomington
Members: 90—District #5—Annual Meeting:
December

MACON COUNTY

President: Clarence G. Glenn, 148 N. Edward St.,
Decatur
Secretary: William T. Couter, 1314 N. Main St.,
Decatur
Executive Secretary: Mrs. Mary Jean Bretz, St.
Mary's Hospital, Decatur
Members: 136—District #7—Annual Meeting:
December

MACOUPIN COUNTY

President: Augustinas Laucis, Mt. Olive
Secretary: Joseph J. Grandone, 109 W. Pine St.,
Gillespie
Members: 25—District #6—Annual Meeting:
November

MADISON COUNTY

President: Willis W. Bowers, 1820 Delmar Ave.,
Granite City
Secretary: Leo R. Green, 1114 Milton Rd., Alton
Members: 127—District #6—Annual Meeting:
December

MARION COUNTY

President: E. F. Stephens, Jr., 1207 E. Broad-
way, Centralia
Secretary: O. J. Burroughs, 202 E. Third St.,
Centralia
Members: 31—District #7—Annual Meeting:
December

MASON COUNTY

President: Donald L. Stehr, 527 N. Broadway,
Havana
Secretary: George A. Kudirka, 101 W. Elm.
Mason City
Members: 12—District #5—Annual Meeting:
April

MASSAC COUNTY

President: George Green, Metropolis
Secretary: Enrique Yap, 510 W. 10th St.,
Metropolis
Members: 8—District #9

MENARD COUNTY

President: Paul L. Purdy, 116 N. Fifth St.,
Petersburg
Secretary: H. K. Moulton, 119 N. Seventh St.,
Petersburg
Members: 3—District #5—Annual Meeting:
March

MERCER COUNTY

President: John Bohan, Alexis
Secretary: J. W. Hastings, 610 S. Maple St.,
Aledo
Members: 5—District #4

MONROE COUNTY

President: E. H. Schaller, 305 E. Fifth St.,
Waterloo
Secretary: F. W. Gebhardt, P. O. Box 110,
Columbia
Members: 9—District #10—Annual Meeting:
March

MONTGOMERY COUNTY

President: Vincent Parlante, 113 W. Wood St.,
Hillsboro
Secretary: George Telfer, 400 Rountree, Hillsboro
Members: 16—District #5—Annual Meeting:
December

MORGAN COUNTY

President: Paul M. Norris, 200 W. State St.,
Jacksonville
Secretary: R. H. Kooiker, 801 Lincoln Ave.,
Jacksonville
Members: 44—District #6—Annual Meeting:
December

MOULTRIE COUNTY

President: H. E. Kendall, Sullivan
Secretary: Dean McLaughlin, Sullivan
Members: 6—District #7

OGLE COUNTY

President: Donald K. Johnston, 102 Kable Square, Mt. Morris
 Secretary: Lloyd Thomas Koritz, 324 Lincoln Ave., Rochelle
 Members: 21—District #1—Annual Meeting: October

PEORIA COUNTY

President: Frederick Z. White, 427 First National Bank, Peoria
 Secretary: Robert S. Easton, 427 First National Bank, Peoria
 Executive Secretary: Mr. David W. Meister, 427 First National Bank, Peoria
 Members: 239—District #4—Annual Meeting: December

PERRY COUNTY

President: J. A. Mathis, Pinckneyville Medical Group, Pinckneyville
 Secretary: James B. Stotlar, Medical Arts Building, Pinckneyville
 Members: 14—District #10—Annual Meeting: December

PIATT COUNTY

President: William Scott, Bement
 Secretary: George G. Green, 121 N. State St., Monticello
 Members: 9—District #7—Annual Meeting: December

PIKE COUNTY

President: Myer Shulman, 112 W. Jefferson St., Pittsfield
 Secretary: James H. Rutledge, 226 S. Monroe St., Pittsfield
 Members: 12—District #6—Annual Meeting: December

PULASKI COUNTY

President: James Conger, Mounds
 Secretary: Burton Bagby, Mounds
 Members: 2—District #10—Annual Meeting: January

RANDOLPH COUNTY

President: R. E. Schettler, Red Bud
 Secretary: L. C. Fiene, 118 W. Broadway, Sparta
 Members: 15—District #10—Annual Meeting: January

RICHLAND COUNTY

President: Wayne C. Moulton, 1030 E. Main St., Olney
 Secretary: Thomas E. Benson, 1400 E. Locust St., Olney
 Members: 24—District #8—Annual Meeting: December

ROCK ISLAND COUNTY

President: C. J. Weissmann, 1508 Seventh St., Moline
 Secretary: D. W. Murrell, 532—19th Ave., Moline
 Members: 136—District #4—Annual Meeting: December

ST. CLAIR COUNTY

President: Herbert Dexheimer, 301 S. Illinois St., Belleville
 Secretary: Charles Frazer, 258 N. 14th St., East St. Louis
 Executive Secretary: Mr. Eugene Conrad, 4825 W. Main St., Belleville
 Members: 167—District #10—Annual Meeting: October

SALINE-POPE-HARDIN COUNTY

President: Frank Skaggs, 11 E. Poplar, Harrisburg
 Secretary: William J. Blackard, Harrisburg Hospital, Harrisburg
 Members: 20—District #9—Annual Meeting: January

SANGAMON COUNTY

President: Robert J. Patton, 107 S. Fifth St., Springfield
 Secretary: William DeHollander, St. John's Hospital, Springfield
 Members: 186—District #5—Annual Meeting: June

SCHUYLER COUNTY

President: Verne M. Corman, Rushville
 Secretary: Henry C. Zingher, Rushville Clinic, Rushville
 Members: 5—District #4—Annual Meeting: January

SHELBY COUNTY

President: Smith D. Taylor, Windsor
 Secretary: Richard H. Larson, 400 S. Walnut St., Shelbyville
 Members: 15—District #7—Annual Meeting: January

STEPHENSON COUNTY

President: Philip L. Wachtal, 222 W. Exchange St., Freeport
 Secretary: John E. Madden, 420 S. Harlem St., Freeport
 Members: 40—District #1—Annual Meeting: January

TAZEWELL COUNTY

President: Joseph Aronoff, 427 First National Bank, Peoria
 Secretary: Harry B. Shepard, 427 First National Bank, Peoria
 Executive Secretary: Mr. David W. Meister, 427 First National Bank Building, Peoria
 Members: 44—District #5—Annual Meeting: December

UNION COUNTY

President: John E. Pfau, 108 E. Davie St., Anna
 Secretary: William H. Whiting, P. O. Box 410, Anna
 Members: 10—District #10—Annual Meeting: December

VERMILION COUNTY

President: Stanley L. Levin, 909 N. Logan Ave.,
Danville
Secretary: L. W. Tanner, 7 N. Virginia Ave.,
Danville
Members: 87—District #8—Annual Meeting:
December

WABASH COUNTY

President: Robert A. Riehey, Grayville
Secretary: C. L. Johns, 114 W. Fifth St., Mt.
Carmel
Members: 5—District #9—Annual Meeting:
January

WARREN COUNTY

President: James W. Marshall, 319 N. Main St.,
Monmouth
Secretary: Glenn W. Chamberlin, 219 E. Euclid
Ave., Monmouth
Members: 13—District #4—Annual Meeting:
January

WASHINGTON COUNTY

President: Peter Fajans, Okawville
Secretary: W. P. Lesko, 112 N. Mill St., Nashville
Members: 7—District #10—Annual Meeting:
January

WAYNE COUNTY

President: E. S. Talaga, 101 E. Center St.,
Fairfield
Secretary: Sigmund W. Konarski, 101 E. Center
St., Fairfield
Members: 8—District #9—Annual Meeting:
December

WHITE COUNTY

President: William H. Courtnage, 203 S. Church
St., Carmi
Secretary: Philip D. Boren, Doctor's Clinic,
Carmi
Members: 8—District #9—Annual Meeting:
December

JOINT COUNTY SOCIETIES

Cass-Brown
Coles-Cumberland
Jefferson-Hamilton
Jersey-Calhoun
Saline-Pope-Hardin
Will-Grundy

WHITESIDE COUNTY

President: John J. McDonnell, Professional Bldg.,
Rock Falls
Secretary: LaMonte Ballard, 102 E. Miller Rd.,
Sterling
Members: 44—District #2—Annual Meeting:
June

WILL-GRUNDY COUNTY

President: Robert J. Becker, 702 W. Palladium,
Joliet
Secretary: John H. Kendall, 502 W. Palladium
Dr., Joliet
Executive Secretary: Mr. Robert Best, 305 N.
Ottawa St., Joliet
Members: 167—District #11—Annual Meeting:
November

WILLIAMSON COUNTY

President: C. E. Boyd, Bank of Marion, Marion
Secretary: Herbert V. Fine, 110 N. Division St.,
Carterville
Members: 25—District #9—Annual Meeting:
February

WINNEBAGO COUNTY

President: Gordon T. Burns, 2300 N. Rockton
Ave., Rockford
Secretary: Joseph B. Perez, 6670 E. State St.,
Rockford
Executive Secretary: Mr. Donald A. Westbrook,
310 N. Wyman St., Rockford
Members: 249—District #1

WOODFORD COUNTY

President: Robert P. Lykkebak, El Paso
Secretary: Victor Jay, Washburn
Members: 14—District #2—Annual Meeting:
November

NO ORGANIZED SOCIETY

Gallatin	Scott
Marshall	Stark
Putnam	

COMMITTEES

Committees of the Illinois State Medical Society are either provided for in the bylaws of the Society or are appointed by the Board of Trustees. Members of committees provided for in the bylaws are either elected by the House of Delegates or appointed by the Board of Trustees for three-year terms. All other committees are appointed by the Board annually.

COMMITTEE ON AGING (Board of Trustees)

Edward W. Cannady, *Chairman*
4601 State St., East St. Louis

Preston V. Dilts
1025 S. Seventh St., Springfield

William K. Ford
303 N. Main St., Rockford

Edward E. Gordon
9219 East End Ave., Chicago

Joseph R. Mallory
Link Clinic, Mattoon

Ernest G. McEwen
2500 Ridge Ave., Evanston

Henry T. Ricketts
950 E. 59th St., Chicago

Martin H. Seifert
1035 Forest Ave., Wilmette

Roger F. Sondag
518 State Office Bldg., Springfield

Thomas T. Turlentes
Research Hospital, Galesburg

Henry M. Wilson, Jr.
1101 Main St., Peoria

AUXILIARY REPRESENTATION:
Mrs. Howard A. Lowy
112 Pekin Ave., East Peoria

STAFF: Walter R. Livingston

Responsibilities and Purposes

The functions of the Committee on Aging encompass the broad field of aging with special consideration for the types of medical services and patterns of care available to the aging and the economics involved. The committee cooperates with the American Medical Association's Committee on Aging and other appropriate agencies.

Included among the committee's activities are the study and support of expansion of additional home care programs in Illinois; relationships with nursing homes, home nursing, homemaker programs, and other programs involving services oriented toward the aging; and liaison with other agencies having a similar interest.

for August, 1965

COMMITTEE ON ARCHIVES (Bylaws)

	Term Expires
Emmet F. Pearson, <i>Chairman</i> 701 N. Walnut, Springfield	1967
Charles Hagler 1101 Maine St., Quincy	1968
Clifford E. Smith 261 E. Lincoln Hwy., DeKalb	1968
Leo Zimmerman 55 E. Washington St., Chicago	1966
STAFF: Paul S. Swarts	

Responsibilities and Purposes Described in Constitution and Bylaws

SUBCOMMITTEE ON MUSEUM OF MEDICAL HISTORY

The Committee on the Museum of Medical History shall be a subcommittee of the Archives Committee, and shall be responsible for the establishment of a Museum of Medical Progress in Illinois. It shall collect items of medical historical importance and cooperate with the Historical Museum of the State of Illinois and various historical societies in the education of the public on the importance of medicine as it pertains to the documentation of the progress which has been made in the care and treatment of patients in Illinois.

BENEVOLENCE COMMITTEE (Bylaws)

	Term Expires
Keith H. Frankhauser, <i>Chairman</i> Avon	1967
Raleigh C. Oldfield 715 Lake St., Oak Park	1966
John H. Steinkamp 824 Van Buren St., Belvidere	1968
STAFF: Paul S. Swarts	

Responsibilities and Purposes Described in Constitution and Bylaws

LIAISON COMMITTEE TO BLUE CROSS-BLUE SHIELD

(Board of Trustees)

Clifton L. Reeder, *Chairman*

310 S. Michigan Ave., Chicago

Chairman, Committee on Medical Economics

C. Elliott Bell

964 Citizens Bldg., Decatur

Chairman, Committee on Relative Value

Maurice M. Hoeltgen

1836 W. 87th St., Chicago

*Chairman, Committee on Prepayment Plans
and Organizations*

Daniel Ruge

700 N. Michigan Ave., Chicago

Chairman, Committee on Medical Education

STAFF: Walter R. Livingston

Responsibilities and Purposes

The function of the committee is to provide a channel of communication between Blue Cross-Blue Shield Plans and the Illinois State Medical Society on matters of mutual concern. Specific problems which may arise as a result of this liaison will be referred to appropriate committees for detailed study.

COMMITTEE ON CANCER CONTROL

(Board of Trustees)

Augusta Webster, *Chairman*

55 E. Washington St., Chicago

Kent W. Barber

1416 Maine St., Quincy

Warren H. Cole

840 S. Wood St., Chicago

Robert E. Field

13000 S. Maple Ave., Blue Island

Russell M. Jensen

319 N. Main St., Monmouth

Franklin J. Moore

55 E. Washington St., Chicago

R. G. Mrazek

3239 S. Oak Park Ave., Berwyn

W. R. Scott

Carbondale Clinic, Carbondale

Thomas Sellett

101 E. Miller Rd., Sterling

R. F. Sondag

518 State Office Bldg., Springfield

EX-OFFICIO:

J. Ernest Breed

55 E. Washington St., Chicago

Caesar Portes

25 E. Washington St., Chicago

AUXILIARY REPRESENTATION:

Mrs. Allan S. Watson

692 Lenox Road, Glen Ellyn

STAFF: Albert G. Boeck

Responsibilities and Purposes

The committee shall serve as a source of information on cancer matters for the ISMS. It shall evalu-

ate available information and make recommendations to the Board on the position the ISMS should take in this area of scientific endeavor. It shall cooperate with institutions and voluntary health agencies in disseminating information on cancer subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

COMMITTEE ON CARDIOVASCULAR DISEASE

(Board of Trustees)

Oglesby Paul, *Chairman*

303 E. Superior St., Chicago

Wright Adams

950 E. 59th St., Chicago

Hugh S. Espey

25 Lincoln Hill, Quincy

Arnold S. Moe

4601 State St., East St. Louis

A. Paul Naney

433 E. 7th, Flora

Eugene Scherba

13826 Lincoln Ave., Dolton

STAFF: Albert G. Boeck

Responsibilities and Purposes

The committee shall serve as a source of information on cardiovascular disease matters for the ISMS. It shall evaluate available information and make recommendations to the Board for the position the ISMS should take on issues in this area of scientific endeavor. It shall cooperate with institutions and voluntary health agencies in disseminating information on cardiovascular subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

COMMITTEE TO STUDY THE POLICIES OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

Edward A. Piszezsek, *Chairman*

6410 N. Leona Ave., Chicago

Newton DuPuy

1101 Maine St., Quincy

Burtis E. Montgomery

37 S. Main St., Harrisburg

EX-OFFICIO: Robert L. Richards

STAFF: Robert L. Richards

Responsibilities and Purposes

The purpose of the committee is inherent in its title, but if the committee finds reason to believe that the policies of the Chamber should be altered, it will be necessary to schedule a hearing with the Policy Committee of the Chamber. Procedures for changes in policy are firmly established. Copies of the Chamber Policies are available to the committee.

COMMITTEE ON CHILD HEALTH

(Board of Trustees)

Ralph H. Kunstadter, *Chairman*
664 N. Michigan Ave., Chicago

Irving R. Abrams
6342 Sheridan Rd., Chicago

Oliver Crawford
3233 South Parkway, Chicago

Eugene F. Diamond
11055 S. St. Louis Ave., Chicago

R. E. Dukes
602 W. University Ave., Urbana

W. W. Fullerton
101 N. Market St., Sparta

Edmond R. Hess
1737 W. Howard St., Chicago

H. R. Hone
151 Herrick Rd., Riverside

Eduard Jung
13826 Lincoln Ave., Dolton

Edward F. Lis
840 S. Wood St., Chicago

Fred P. Long
2116 N. Sheridan Rd., Peoria

J. Keller Mack
922 S. 4th St., Springfield

Franklin A. Munsey
1429 Myott Ave., Rockford

Kenneth S. Nolan
172 Schiller St., Elmhurst

Leo G. Perucca
602 W. University Ave., Urbana

William H. Schwingel
57 E. Downer Pl., Aurora

Walter G. Steiner
140 W. Sale St., Tuscola

Norman T. Welford
656—58th St., Hinsdale

W. M. Whitaker
1416 Maine St., Quincy

STAFF: Albert G. Boeck

Responsibilities and Purposes

The committee shall serve as a source of information on matters pertaining to child health. It shall evaluate available information and make recommendations to the Board for the position the ISMS should take on issues in this area and co-operate with institutions and voluntary health agencies in

disseminating information pertinent to general child health. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public. It shall conduct educational programs for public enlightenment for the encouragement and the establishment of school health councils; and strive for increased services for exceptional children. It shall conduct, in cooperation with the Maternal Welfare Committee, research on neonatal mortality through the state; and seek the formulation and adoption of uniform school health records.

COMMITTEE TO STUDY COMMITTEES

(Board Members Only)

Wm. H. Schowengerdt, *Chairman*
301 E. University Ave., Champaign

Ted LeBoy
330 Gale Ave., River Forest

Joseph R. O'Donnell
444 Park Ave., Glen Ellyn

Jacob E. Reisch
1129 S. 2nd St., Springfield

Charles K. Wells
117 N. 10th St., Mt. Vernon

STAFF: Robert L. Richards

COMMITTEE ON CONSTITUTION AND BYLAWS

(Bylaws)

	Term Expires
Andrew J. Brislen, <i>Chairman</i> 6060 S. Drexel Blvd., Chicago	1968
David S. Fox 826 E. 61st St., Chicago	1967
Wayne N. Leimbach 987 Oak Ave., Aurora	1967
M. Mijanovich 556 E. Grant St., Marengo	1966
Charles J. Weigel 7579 Lake St., River Forest	1966

EX-OFFICIO:

E. W. Cannady
Speaker, House of Delegates

STAFF: Frances C. Zimmer

*Responsibilities and Purposes Described in
Constitution and Bylaws*

COMMITTEE ON CONTINUING EDUCATION (Board of Trustees)

Robert J. Freeark, *Chairman*
Cook County Hospital,
1825 W. Harrison St., Chicago

Hubert L. Allen
D'Adrian Medical Park
1312 W. Delmar, Godfrey
Washington University (Missouri)

William R. Barclay
950 E. 59th St., Chicago
University of Chicago

T. Howard Clarke
251 E. Chicago Ave., Chicago
Passavant Memorial Hospital

Richard DeWall
2755 W. 15th St., Chicago
Chicago Medical School

Jack L. Gibbs
24 Main St., Canton

Edwin N. Irons
122 S. Michigan Ave., Chicago
Presbyterian-St. Luke's Hospital

Ralph H. Kunstadter
664 N. Michigan Ave., Chicago
Michael Reese Hospital

Louis R. Limarzi
910 N. East Ave., Oak Park
University of Illinois

Mather Pfeifferberger
200 W. Third St., Alton
St. Louis University (Missouri)

Joseph H. Skom
303 E. Superior St., Chicago
Northwestern University

Gordon Sprague
Medical Center Clinic, Paris

William R. Thompson
1640 Dartmouth Ln., Deerfield

EX-OFFICIO:
William E. Adams
950 E. 59th St., Chicago

STAFF: Albert G. Boeck

Responsibilities and Purposes

The committee shall provide a program of continuing education for the practicing physicians of Illinois. This shall include courses in specific medical subjects as requested by component societies as well as speakers on scientific subjects. The committee shall solicit individuals or teams from the medical schools in Illinois, the hospitals and research centers and the body of practitioners to present this program of continuing education. It shall study more effective means of presenting educational material throughout the state. It shall provide additional services to component societies as are deemed necessary to the conduct of an effective program.

COMMITTEE TO STUDY THE CONVENTION (Board of Trustees)

George F. Lull, *Chairman*
400 E. Randolph St., Chicago

William M. Lees, *Vice Chairman*
7000 N. Kenton Ave., Lincolnwood

E. Chester Bone
800 W. State St., Jacksonville

Edwin S. Hamilton
151 N. Schuyler Ave., Kankakee

H. Marchmont-Robinson
14 E. Jackson Blvd., Chicago

Norman E. Powers
3125 Prospect Rd., Peoria

STAFF: Albert G. Boeck

Responsibilities and Purposes

This committee was appointed to make a five-year study of the ISMS Annual Convention; to review and evaluate its scientific effectiveness; to study its pattern of relying on scientific sections for the major portion of the program; to judge its value to Illinois physicians; and to recommend to the Committee on Scientific Assembly any changes which would improve the convention.

COMMITTEE ON DISASTER MEDICAL CARE (Bylaws)

	Term Expires
Max Klinghoffer, <i>Chairman</i> 127 E. Vallette St., Elmhurst	1967
Jack R. Baldwin 1315 S. Sixth St., Springfield	1968
Richard V. Lee University Health Service, Carbondale	1966
Harold C. Lueth 636 Church St., Evanston	1967
Carl F. Steinhoff 720 N. Michigan Ave., Chicago	1966
AUXILIARY REPRESENTATION:	
Mrs. Bruno Beinoris 295 Forest View Ave., Wood Dale	
STAFF: James Slawny	

Responsibilities and Purposes Described in Constitution and Bylaws

MEDICAL SELF-HELP TRAINING SUBCOMMITTEE

Jack Baldwin, *Chairman*

Leonard F. Roblee
1000 State St., Lockport

George Saxl
111 W. Grand Ave., Bensenville

Franklin D. Yoder
State Office Bldg., Springfield

Edward N. Zinschlag
Link Clinic, Mattoon

SUBCOMMITTEE ON BLOOD AND BLOOD SUBSTITUTES

Harold C. Lueth, *Chairman*

James B. Hartney
410 Lake St., Oak Park

Leonard F. Roblee

COMMITTEE ON DRUG MANUAL
(Board of Trustees)

Robert C. Muehreke, *Chairman*
518 N. Austin Blvd., Oak Park
James A. Weatherly, *Vice Chairman*
108 N. 14th St., Murphysboro
Charles R. Frazer, Jr.
258 N. 14th St., East St. Louis
Edsel K. Hudson

5054 S. Woodlawn Ave., Chicago
Theodore R. Van Dellen
435 N. Michigan Ave., Chicago

CONSULTANTS:

Theodore R. Sherrod, Ph.D., M.D.
1853 W. Polk St., Chicago
Louis Gdalan, R.Ph.
1753 W. Congress Pkwy., Chicago

STAFF: Walter R. Livingston

Responsibilities and Purposes

The committee will continue to work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the membership are submitted to the committee, it will review them and present them to the Department of Public Aid when necessary. All matters affecting changes in policy should be coordinated with the Medical Advisory Committee.

EDITORIAL BOARD
(Board of Trustees)

Samuel A. Levinson, *Chairman*
3730 Lake Shore Dr., Chicago
Frederick H. Falls
P.O. Box 47, River Forest
Edwin F. Hirsch
5830 Stony Island Ave., Chicago
James H. Hutton
67 E. Madison St., Chicago
Julius M. Kowalski
436 Park Ave., East, Princeton
Harvey Kravitz
6420 N. California St., Chicago
Francis L. Lederer
1853 W. Polk St., Chicago
Charles Mrazek
1210 Robinhood Ln., LaGrange Park
Clarence J. Mueller
108 W. 4th St., Sterling
Jacob E. Reisch
1129 S. 2nd St., Springfield
E. Clinton Texter, Jr.
700 N. Michigan Ave., Chicago
Arnell M. Vaughn
2015 E. 79th St., Chicago
Edward F. Webb
5112 Oakton St., Skokie
STAFF: Albert G. Boeck

Responsibilities and Purposes

The responsibilities of this committee lie in the area of the editorial content of the Illinois Medical
for August, 1965

Journal. It shall make recommendations to the editor concerning the scientific content, regular features and subjects of special interest to the members. It shall serve as a review board for manuscripts which the editor believes require special medical evaluation. It shall assist the editor in any way possible to obtain and present medical manuscripts of the highest quality and maximum interest to the physicians of Illinois.

EDUCATIONAL & SCIENTIFIC FOUNDATION
(Board Members Only)

Edward A. Piszczek, *Chairman*
6410 N. Leona Ave., Chicago
Immediate Past President

William E. Adams
950 E. 59th St., Chicago
Chairman of the Board

Burtis E. Montgomery
37 S. Main St., Harrisburg
President

Jacob E. Reisch
1129 S. 2nd St., Springfield
Secretary-Treasurer

EX-OFFICIO:

Robert L. Richards

STAFF: Albert G. Boeck

COMMITTEE ON ENVIRONMENTAL HEALTH
(Board of Trustees)

Edward Press, *Chairman*
202 Burnham Pl., Evanston

Robert J. Maganini
727 W. Hickory, Hinsdale

Clark W. Mangun, Jr.
433 W. Van Buren St., Chicago

Howard C. Burkhead
Evanston Hospital Association
2650 Ridge Ave., Evanston
Chairman, Committee on Radiation

James B. Hartney
410 Lake St., Oak Park
Chairman, Committee on Laboratory Evaluation

Edward C. Holmblad
1350 Lake Shore Dr., Chicago
Chairman, Committee on Occupational Health

Ralph H. Kunstadter
664 N. Michigan Ave., Chicago
Chairman, Committee on Child Health

Joseph H. Skom
303 E. Superior St., Chicago
Chairman, Committee on Narcotics & Hazardous Substances

Franklin D. Yoder
503 State Office Bldg., Springfield
Director, Department of Public Health

STAFF: Albert G. Boeck

Responsibilities and Purposes

The committee is responsible for medicine's interest in the relationship of man to his surroundings, particularly those areas which pertain to the

control of transmissible disease; air, water and soil pollution; health problems related to population growth; urbanization and technicological developments bearing on the ecology of man.

ETHICAL RELATIONS COMMITTEE (Board Members Only)

Willard C. Scrivner, *Chairman*
4601 State St., East St. Louis

J. Ernest Breed
55 E. Washington St., Chicago

William M. Lees
7000 N. Kenton Ave., Lincolnwood

Edward A. Piszczek
6410 N. Leona Ave., Chicago

Paul P. Youngberg
1520 Seventh Ave., Moline

STAFF: James Slawny

Responsibilities and Purposes

The responsibilities of this committee include matters involving interpretations of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the ISMS, and its component societies, and charges of misconduct against members of the Society. It shall serve as an appellate body to hear and review cases involving these matters arising from appeals made to the Board by members of the Society.

COMMITTEE ON EYE HEALTH (Board of Trustees)

Frank W. Newell, *Chairman*
950 E. 59th St., Chicago

Peter C. Kronfeld
1853 W. Polk St., Chicago

Walter Stevenson
1124 Broadway, Quincy

Manuel Stillerman
111 N. Wabash Ave., Chicago

M. Byron Weisbaum
1211 S. 6th St., Springfield

STAFF: Albert G. Boeck

Responsibilities and Purposes

The committee shall serve as a source of information on eye health matters for the ISMS. It shall evaluate available information and make recommendations to the Board for the position the ISMS should take on issues in this area, and cooperate with institutions and voluntary health agencies in disseminating information on eye health subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

COMMITTEE ON FEE SCHEDULES (Board of Trustees)

George F. Lull, *Chairman*
400 E. Randolph St., Chicago

Franklin J. Moore, *Vice Chairman*
55 E. Washington St., Chicago

C. Elliott Bell
964 Citizens Bldg., Decatur

Maurice M. Hoeltgen
1836 W. 87th St., Chicago

Carl F. Steinhoff
720 N. Michigan Ave., Chicago

STAFF: Walter R. Livingston

Responsibilities and Purposes

The functions of the Committee on Fee Schedules include the periodic review of the adequacy and the appropriateness of payment schedules resulting from negotiations by the Illinois State Medical Society on behalf of its membership. Upon request of, and with the approval of the Board of Trustees, the committee may renegotiate fee schedules at appropriate intervals. In conjunction with the activities of other committees, the committee may be called upon to review benefit schedules under prepayment plans, health insurance plans, or consumer-sponsored health care plans.

FIFTY YEAR CLUB COMMITTEE (Board of Trustees)

George F. Lull, *Chairman*
400 E. Randolph St., Chicago

Morris Fishbein
5454 South Shore Dr., Chicago

G. C. Otrich
110 N. High St., Belleville

Walter H. Theobald
307 N. Michigan Ave., Chicago

STAFF: James Slawny

Responsibilities and Purposes

This committee shall administer the activities of the "club," composed of physicians who have practiced medicine for 50 years or more. The committee makes arrangements for the annual complimentary luncheon held during the annual convention, honoring members of the club.

GRIEVANCE COMMITTEE (Bylaws)

	Term Expires
Arkell M. Vaughn, <i>Chairman</i>	
2015 E. 79th St., Chicago	1967
A. K. Baldwin	
229 Fifth St., Carrollton	1967
Allison L. Burdick, Sr.	
5906 W. North Ave., Chicago	1968
Frank H. Fowler	
6356 Diversey Ave., Chicago	1966
Victor V. Rockey	
324 W. Galena Ave., Freeport	1966
William H. Walton	
109 S. High St., Belleville	1968
STAFF: James Slawny	

*Responsibilities and Purposes Described in
Constitution and Bylaws*

MEDICAL ADVISORY COMMITTEE TO THE HEALTH CAREERS COUNCIL OF ILLINOIS

Maynard I. Shapiro, *Chairman*
7531 Stony Island Ave., Chicago
Allison L. Burdick, Jr.
1637 North Mobile Ave., Chicago
Jack L. Gibbs
24 Main St., Canton
Edward A. Piszczek
6410 N. Leona Ave., Chicago
Francis W. Young
10025 Hamilton Ave., Chicago
STAFF: James Slawny

Responsibilities and Purposes

This committee is responsible for advising the Health Careers Council of Illinois on all matters regarding careers in medicine. It shall also advise and assist the council in the development of new financial resources needed to maintain its operation. The chairman of this committee shall be the designated representative to HCCI and shall report to the Board of Trustees.

COMMITTEE ON HOSPITAL RELATIONS

(Board of Trustees)

Noel G. Shaw, *Chairman*
2901 Central St., Evanston
John A. Bowman
300 N. Main St., Abingdon
J. W. Buser
4601 State St., East St. Louis
John M. Dorsey
636 Church St., Evanston
Harlan English
909 N. Logan Ave., Danville
Kenneth John Smith
2320 High St., Blue Island
N. A. Thompson
1301 Pine St., Eldorado
EX-OFFICIO:
Casper Epsteen
25 E. Washington St., Chicago
STAFF: Walter R. Livingston

Responsibilities and Purposes

Among the functions of the committee are the consideration of all problems bearing on the relationship between physicians and hospitals except those pertaining to medical training. A prime objective of the committee is to encourage hospital staffs to become actively interested in the economics of hospital operation and hospital services. In areas of health insurance, nursing and items requiring legislative action, the committee should coordinate its activities with the respective committees of the Society to avoid duplication of effort.

The committee will continue to work toward solving mutual problems pertaining to hospital utilization; medical, nursing and administrative care of

patients; hospital costs; accreditation of non-accredited hospitals; and to improve physician-hospital relationships in the interest of patient care.

ILLINOIS ASSOCIATION OF PROFESSIONS COMMITTEE

(Board of Trustees)

George B. Callahan, *Chairman*
4 S. Genesee St., Waukegan
Charles Allison
1309 E. Court St., Kankakee
Andrew J. Brislen
6060 S. Drexel Ave., Chicago
James D. Majarakis
30 N. Michigan Ave., Chicago
Eugene M. Narsete
145 S. Northwest Hwy., Park Ridge
Edward A. Piszczek
6410 N. Leona Ave., Chicago
Vincent C. Sarley
811 W. Wellington Ave., Chicago
EX-OFFICIO:
Michael R. Saxon
Robert L. Richards
STAFF: Robert L. Richards

Responsibilities and Purposes

The responsibilities of this committee have been established by the Board of Trustees as follows: "Maintain general liaison with the officers and members of other professions . . . formally associate themselves into a body to represent the broad professions within the state . . . conduct programs and activities which will enhance the relationships among the professions."

A further responsibility of this committee is to have a subcommittee serve in liaison with the Interprofessional Council: "The purpose of the subcommittee is to meet monthly with the Interprofessional Council, provide to them that information which is deemed important for an understanding between the groups represented on the Council, to co-operate with the Interprofessional Council on their Distinguished Service Award, and other programs of mutual interest."

SUBCOMMITTEE—TO PROVIDE LIAISON WITH INTERPROFESSIONAL COUNCIL

Andrew J. Brislen, *Chairman*
6060 S. Drexel Ave., Chicago
Lawrence J. Bowness
9135 S. Exchange Ave., Chicago
James D. Majarakis
30 N. Michigan Ave., Chicago
Walter J. Reedy
814 Washington St., Waukegan
David Whitsell
1832 E. 87th St., Chicago

LIAISON COMMITTEE TO ILLINOIS OSTEOPATHIC ASSOCIATION

(Board of Trustees)

Walter C. Bornemeier, *Chairman*
4665 Peterson Ave., Chicago

Allison L. Burdick, Sr.
5906 W. North Ave., Chicago

Harlan English
909 N. Logan Ave., Danville

H. Close Hesseltine
5841 S. Maryland Ave., Chicago

George F. Lull
400 E. Randolph St., Chicago

Leo P. A. Sweeney
10725 S. Western Ave., Chicago

EX-OFFICIO:

John W. Neal
310 S. Michigan Ave., Chicago

STAFF: John W. Neal

Responsibilities and Purposes

The responsibilities of this committee are to assist in developing rapport, cooperation with and understanding of the osteopathic profession. It shall function when requested to do so either by (1) The American Medical Association; (2) The Illinois State Medical Society; (3) The Illinois Osteopathic Association.

Its findings in any specific instance shall be reported to either the Board of Trustees or the House of Delegates for consideration and action.

LIAISON COMMITTEE TO ILLINOIS PHARMACEUTICAL ASSOCIATION

(Board of Trustees)

George B. Callahan, *Chairman*
4 S. Genesee St., Waukegan

George F. Lull
400 E. Randolph St., Chicago

Edward A. Piszczek
6410 N. Leona Ave., Chicago

Vincent C. Sarley
118 W. Wellington Ave., Chicago

STAFF: Robert L. Richards

Responsibilities and Purposes

The functions of this committee are to consider problems bearing on the relationship between physicians and pharmacists. A prime objective is to develop a Physicians-Pharmacists Code of Understanding and Cooperation.

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY

(Bylaws)

Term
Expires

Clinton L. Compere, *Chairman*
737 N. Michigan Ave., Chicago 1967

R. Gregory Green
1355 Charles St., Rockford 1967

Roger A. Harvey
840 S. Wood St., Chicago 1966

Samuel A. Levinson
3730 Lake Shore Dr., Chicago 1967

Jerome J. McCullough
110 N. High St., Belleville 1968

Maurice D. Murfin
250 N. Water St., Decatur 1966

Harry D. Nesmith
RFD No. 1, Salem 1966

Vincent C. Sarley
811 W. Wellington Ave., Chicago 1968

Leo P. A. Sweeney
10725 S. Western Ave., Chicago 1968

CONSULTANT:

Edmund F. Foley
359 N. Ridgeland Ave., Oak Park

EX-OFFICIO:

Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest

STAFF: Paul S. Swarts

*Responsibilities and Purposes Described in
Constitution and Bylaws*

JOURNAL COMMITTEE

(Board of Trustees)

Jacob E. Reisch, *Chairman*

1129 S. 2nd St., Springfield

J. Ernest Breed

55 E. Washington St., Chicago

Newton DuPuy

1101 Maine St., Quincy

Frank J. Jirka, Jr.

1507 Keystone Ave., River Forest

Darrell H. Trumpe

St. John's Sanatorium, Springfield

STAFF: Albert G. Boeck

Responsibilities and Purposes

This committee shall be responsible for the production of the *Illinois Medical Journal*. It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the Journal. It shall supervise the editor in the selection and preparation of all copy and it shall establish standards for the editorial content. It shall establish advertising policies, rates, standards and review all new accounts prior to acceptance, and approve reprint and circulation policies. It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the Journal.

COMMITTEE ON LABORATORY EVALUATION

(Bylaws)

	Term Expires
James B. Hartney, <i>Chairman</i> 410 Lake St., Oak Park	1967
Thomas P. deGraffenried Deval Shopping Center, DeKalb	1967
John Maloney 1007 Broadway, Normal	1966
Jack Williams Prudential Plaza, Chicago	1966
Hans Willuhn 1335 Charles St., Rockford	1968
STAFF: Paul S. Swarts	

*Responsibilities and Purposes Described in
Constitution and Bylaws*

COMMITTEE ON LEGISLATION

(Bylaws)

	Term Expires
V. P. Siegel, <i>Chairman</i> 4601 State St., East St. Louis	1968
George B. Callahan 4 S. Genesee St., Waukegan	1967
H. Close Hesseltine 5841 S. Maryland Ave., Chicago	1966
C. J. Jannings, III 101 E. Center St., Fairfield	1966
Harold A. Sofield 715 Lake St., Oak Park	1968

EX-OFFICIO:

J. Ernest Breed
55 E. Washington St., Chicago
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest
Ralph N. Redmond
101 E. Miller Rd., Sterling
Philip G. Thomsen
13828 Lincoln Ave., Dolton

AUXILIARY REPRESENTATION:

Mrs. Fred C. Endres
229 E. Glen Ave., Peoria
Mrs. John Van Prohaska
5830 Stony Island Ave., Chicago

STAFF: Roger N. White

Harold W. Widmer
Clifford Raber

*Responsibilities and Purposes Described in
Constitution and Bylaws*

COMMITTEE ON MATERNAL WELFARE

(Board of Trustees)

Italics indicate alternates

Robert R. Hartman, *Chairman*
316 W. State St., Jacksonville
Frederick H. Falls, *Chairman Emeritus &
Special Consultant*
P.O. Box 47, River Forest
1. Richard F. Whitlock
860 Summit St., Elgin

for August, 1965

V. M. Bowers, Jr.
2500 N. Rockton Ave., Rockford
2. William J. Farley
710 Peoria St., Peru
George E. Giffin
203 Park Ave., East, Princeton
3. Melvin Goodman
13826 Lincoln Ave., Dolton
Charles D. Krause
1700 W. 87th St., Chicago
4. V. B. Adams
301 E. Jefferson, Macomb
Ralph Gibson
1916 N. Knoxville, Peoria
5. William W. Curtis
100 W. Miller, Springfield
Donald M. Barringer
118 Walnut, Lincoln
6. Robert R. Hartman
316 W. State St., Jacksonville
Hubert L. Allen
D'Adrian Medical Park, 1312 W. Delmar,
Godfrey
7. Paul Raber
149 W. King St., Decatur
Phillip C. Lynch
1314 N. Main St., Decatur
8. Ray E. Bucher
605 Logan Ave., Danville
Jack D. Brodsky
301 E. Springfield Ave., Champaign
9. Harry L. Lewis
104 S. Maple St., Benton
Donald R. Risley
319 Market St., Mt. Carmel
10. Berry V. Rife
102 Lafayette St., Anna
James B. Stotlar
Medical Arts Bldg., Pineknayville
11. John J. McLaughlin
1000 W. Jefferson St., Joliet
Charles H. P. Westfall
172 Schiller St., Elmhurst
EX-OFFICIO:
Joseph R. O'Donnell
444 Park Ave., Glen Ellyn
Willard C. Serivner
4601 State St., East St. Louis
CONSULTANTS:
John H. Rendok
Department of Public Health, Springfield
Franklin D. Yoder
Department of Public Health, Springfield
Augusta Webster
Cook County Hospital
1825 W. Harrison St., Chicago
Donaldson F. Rawlings
Department of Welfare, Springfield
STAFF: Albert G. Boeck

Responsibilities and Purposes

The committee shall cooperate with the State Department of Public Health in reducing the maternal mortality rate in Illinois. As a means of

achieving this goal, it shall review all maternal deaths reported and send its evaluation of the management of the case to the attending physician. In similar fashion, it shall cooperate with the Joint Committee to Study Perinatal Mortality to achieve its objectives. Appropriate measures should be taken to share the results of this research with those practitioners in a position to apply it for the benefit of their patients.

ADVISORY COMMITTEE TO MEDICAL ASSISTANTS ASSOCIATION

(Board of Trustees)

Maynard Shapiro, *Chairman*

7531 Stony Island Ave., Chicago

Donald E. Dick

606 S. Riverside Dr., St. Charles

Clarence G. Glenn

152 N. Edward St., Decatur

Thomas R. Harwood

Northwest Community Hospital

800 Central Rd., Arlington Heights

Chauncey C. Maher, Jr.

709 Myers Bldg., Springfield

William G. McCarthy

13826 Lincoln, Dolton

H. H. Pillinger, Jr.

1100 Larkin Ave., Elgin

Fred L. Stuttle

1200 Hamilton Rd., Peoria

Harold Swanberg

P.O. Box 110, Quincy

EX-OFFICIO:

Carl E. Clark

Sycamore

Caesar Portes

25 E. Washington St., Chicago

Philip G. Thomsen

13826 Lincoln, Dolton

STAFF: James Slawny

Responsibilities and Purposes

The committee shall be responsible to the Board for maintaining effective liaison between the Society and the Illinois Medical Assistants Association; it shall cooperate with county medical societies in the establishment of medical assistants associations; and shall, upon request, advise the Medical Assistants Association with respect to programs. The committee shall counsel with the officers and committees of the Medical Assistants Association and serve to maintain channels of communication between the two organizations at all times.

COMMITTEE ON MEDICAL ECONOMICS

(Board of Trustees)

Clifton L. Reeder, *Chairman*

310 S. Michigan Ave., Chicago

Maurice M. Hoeltgen

1836 W. 87th St., Chicago

John J. Holland

511 Bondi Bldg., Galesburg

Lawrence J. Knox

600 E. Main St., Olney

F. Paul LaFata

700 N. Seventh St., Springfield

Philip C. Lynch

1314 N. Main St., Decatur

Clifton L. Reeder

310 S. Michigan Ave., Chicago

Robert E. Schettler

950 E. Market St., Red Bud

Frederick Z. White

723 N. Second St., Chillicothe

STAFF: Walter L. Livingston

Responsibilities and Purposes

The functions of the Committee on Medical Economics shall include its continuing review of the Tax Qualified Investment Program (Keogh); the Retirement Investment Program; the Group Disability Program, and the Group Major Medical Program. The Committee shall continue to investigate various insurance programs that may serve to benefit members of the Society.

The Committee shall continue to assist in the administration of the presently sponsored disability program by performing the adjudication services provided for in the master contract.

Matters having an economic bearing on the practice of medicine, including fact-finding and research studies in the general field of medical economics, shall be brought before this committee for consideration.

COMMITTEE ON MEDICAL EDUCATION

(Bylaws)

	Term Expires
Daniel Ruge, <i>Chairman</i>	
700 N. Michigan Ave., Chicago	1966
Herschel Browns	
1800 Wilson Ave., Chicago	1968
Donald H. Dexter	
Macomb Clinic, Doctors Ln., Macomb	1967
Mather Pfeifferberger	
200 W. Third St., Alton	1966
Clifton L. Reeder	
310 S. Michigan Ave., Chicago	1967
STAFF: Albert G. Boeck	

Responsibilities and Purposes Described in Constitution and Bylaws

MEDICAL-LEGAL COMMITTEE (Bylaws)

	Term Expires
Luis V. Amador, <i>Chairman</i> 700 N. Michigan Ave., Chicago	1968
Clinton L. Compere 737 N. Michigan Ave., Chicago	1967
W. W. Dalitsch 718 Mountain Rd., Lake Bluff	1966
John G. Meyer, Jr. 413 W. Monroe St., Springfield	1966
George C. Turner 670 N. Michigan Ave., Chicago	1966
STAFF: Paul S. Swarts	

*Responsibilities and Purposes Described in
Constitution and Bylaws*

MEMBERSHIP COMMITTEE (Board of Trustees)

H. Close Hesseltine, *Chairman*
5841 S. Maryland Ave., Chicago

W. C. Bornemeier
4665 Peterson Ave., Chicago

Casper Epsteen
25 E. Washington St., Chicago

Harold E. Hinwich
Galesburg State Research Hospital, Galesburg

Joseph O'Malley
6 N. Michigan Ave., Chicago

H. D. Scott, Jr.
800 W. State St., Jacksonville

STAFF: Roland I. King

Responsibilities and Purposes

The responsibilities of this committee have been established by the Board of Trustees as follows: "to aid in any way possible all county medical societies in screening and developing membership for all ethical non-members in the various county areas. No work should be done in any county medical society without a request from the officers thereof."

COMMITTEE ON MENTAL HEALTH (Board of Trustees)

Donald Oken, <i>Chairman</i> 5550 Dorchester Ave., Chicago
Arthur G. Baker 2307 Grand Ave., Waukegan
Walter H. Baer 827 First National Bank Bldg., Peoria
Louis D. Boshes 30 N. Michigan Ave., Chicago
Irving Frank 135 S. Sacramento, Sycamore
Richard J. Graff 100 Barnard Rd., Manteno
Harry D. Nesmith 228 S. Lakeview Dr., Salem
Harry Phillips 7300 State St., East St. Louis
Walter P. Plassman Box 335, Ashley
Albert Rauh 725 S. Second St., Springfield
F. L. Sullivan 3 W. Stephenson St., Freeport

CONSULTANT:

Harold M. Visotsky
160 N. LaSalle St., Chicago

AUXILIARY REPRESENTATION:

Mrs. August Martinucci
1210 Mason Ave., Joliet

STAFF: Albert G. Boeck

Responsibilities and Purposes

The responsibilities of this committee are as follows: It shall serve as a source of information on mental health matters for the ISMS. It shall evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall also co-operate with institutions and voluntary health agencies in disseminating information on mental health subjects to the profession and the public. It shall be on the alert for misleading or fallacious programs and information which need correcting for the protection of the public.

COMMITTEE ON NARCOTICS AND HAZARDOUS SUBSTANCES

(Board of Trustees)

Joseph S. Skom, *Chairman*
303 E. Superior St., Chicago
Earl H. Blair
1836 W. 87th St., Chicago
William U. McReynolds
1101 Maine St., Quincy
R. K. Richards
1534 Alexander Ct., Waukegan
Jordan M. Scher
300 N. State St., Chicago
Ross Schlich
Memorial Hospital, Springfield
George S. Schwerin
7531 Stony Island Ave., Chicago
David M. Slight
25 E. Washington St., Chicago
STAFF: Paul S. Swarts

Responsibilities and Purposes

The functions of this committee are: (1) study, research and dissemination of educational information on narcotics and hazardous substances to members of the medical profession;

(2) to recommend acceptable measures for the control of distribution, the use and disposal of narcotics and hazardous substances, exclusive of radiation products but including poison control;

(3) to cooperate with official and non-official agencies in all matters pertaining to this subject.

COMMITTEE ON NURSING

(Board of Trustees)

W. I. Taylor, *Chairman*
24-28 N. Main St., Canton
T. J. Conley
112 S. Northwest Hwy., Park Ridge
Angelo P. Creticos
67 E. Madison St., Chicago
J. O. Firth
209 W. Broadway, Monmouth
Henrietta Herbolsheimer
5528 Hyde Park Blvd., Chicago
H. J. Kolb
St. Joseph
Nicholas P. Primiano
108 Scott St., Joliet

EX-OFFICIO:

Casper Epsteen
25 E. Washington St., Chicago
Ted LeBoy
330 Gale Ave., River Forest
W. C. Scrivner
4601 State St., East St. Louis

STAFF: Albert G. Boeck

Responsibilities and Purposes

The major objective of this committee is to establish a close professional relationship between the medical and nursing professions for the improve-

ment of the health care of the patient. It should work with representatives of the nursing organizations to obtain sound educational programs for nurses, to improve the working relationships of the doctor and nurse in the hospital, and to help establish work patterns for nurses in the hospital which utilize the full skill of the nurse for the care of the patient. The committee should also assist in programs to recruit more graduate nurses, registered nurses, practical nurses, nurses aids and other ancillary nursing personnel.

COMMITTEE ON NUTRITION

(Board of Trustees)

Paul A. Dailey, *Chairman*
620 N. Main St., Carrollton
James R. Wilson, *Vice Chairman*
P.O. Box 70, Winnetka
Fred C. Endres
229 E. Glen Ave., Peoria
John B. Hall, Jr.
1425 S. Racine Ave., Chicago
Warner H. Newcomb
316 W. State St., Jacksonville
W. I. Taylor
24-28 N. Main St., Canton
EX-OFFICIO:
Paul R. Cannon
R.F.D. 2, Box 56, Yorkville
STAFF: Albert G. Boeck

Responsibilities and Purposes

The Committee shall serve as a source of information on nutrition matters for the ISMS and evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall cooperate with institutions and voluntary health agencies in disseminating information on nutrition subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

COMMITTEE ON OCCUPATIONAL HEALTH

(Bylaws)

	Term Expires
Edward C. Holmblad, <i>Chairman</i> 1350 N. Lake Shore Dr., Chicago	1967
Charles Asbury 5728 N. Woodlawn, Peoria	1966
Arthur S. J. Petersen 11406 S. Parnell Ave., Chicago	1966
Arthur E. Sulek 1902 Seventh St., Rockford	1967
Chester R. Zeiss 208 S. LaSalle St., Chicago	1968
STAFF: Paul S. Swarts	

*Responsibilities and Purposes Described in
Constitution and Bylaws*

JOINT COMMITTEE ON PERINATAL MORTALITY

(Board of Trustees)

Representing:

Child Health Committee

Leo G. Perucca, *Chairman*
602 West University Ave., Urbana
Walter G. Steiner
140 W. Sale St., Tuscola

Maternal Welfare Committee

William W. Curtis, *Co-Chairman*
100 W. Miller, Springfield
Robert R. Hartman
316 W. State St., Jacksonville
Harry L. Lewis
104 S. Maple St., Benton

Illinois Society of Obstetrics and Gynecology

Paul A. Dailey
620 N. Main St., Carrollton

Illinois Chapter, American Academy of Pediatrics

Eugene L. Slotowski
5330 W. Devon Ave., Chicago

Illinois Chapter, Academy of General Practice

Simon Y. Saltman
7531 Stony Island Ave., Chicago

Illinois Department of Public Health

Donaldson F. Rawlings
500 State Office Bldg., Springfield
John H. Rendok
500 State Office Bldg., Springfield

Illinois Hospital Association

John A. Taft, Jr.
Administrator, Delnor Hospital, St. Charles

Illinois Nursing Society

Velma Foresman, R.N.
1900 W. Polk St., Chicago

STAFF: Albert G. Boeck

Responsibilities and Purposes

This committee shall seek to establish a method of obtaining pertinent information on all perinatal mortality cases in Illinois; to evaluate these cases and propose a program for the reduction of perinatal deaths; to conduct an educational campaign among physicians to implement this program and to recommend such educational programs among lay groups as will contribute to the reduction of the incidence of perinatal mortality cases.

POLICY COMMITTEE

(Board Members Only)

Newton DuPuy, *Chairman*

Arthur F. Goodyear

Frank J. Jirka

STAFF: Frances C. Zimmer

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATION

(Bylaws)

Term
Expires

Maurice M. Hoeltgen, *Chairman*
1836 W. 87th St., Chicago

1967

Philip C. Lynch

1314 N. Main St., Decatur

1966

for August, 1965

Michael R. Saxon

Oswego

1967

H. Kenneth Scatcliff

1415 Greenleaf Ave., Chicago

1966

E. Lee Strohl

122 S. Michigan Ave., Chicago

1968

STAFF: Walter R. Livingston

Responsibilities and Purposes Described in Constitution and Bylaws

COMMITTEE ON PUBLIC AFFAIRS

(Board of Trustees)

Theodore Grevas, *Chairman*

1800 Third Ave., Rock Island

William F. Ashley

6545 W. 33rd St., Berwyn

Francis E. Bihss

4601 State St., East St. Louis

Carl P. Birk

321 W. Williams St., Decatur

Walter C. Bornemeier

4665 W. Peterson Ave., Chicago

William W. Boswell

2500 N. Rockton Ave., Rockford

Herschel Browns

4600 N. Ravenswood Ave., Chicago

Donald E. Clark

Memorial Hospital, Springfield

Edwin L. Falloon

9450 S. Francisco Ave., Evergreen Park

Justin Fleischmann

320 S. Ela Rd., Palatine

Arthur W. Fleming

10400 S. Western Ave., Chicago

Glen H. Harrison

1616 Grand Ave., Waukegan

W. Robert Maloney

Carbondale Clinic, Carbondale

John A. Newkirk

370 Summit St., Elgin

John W. Ovitz, Jr.

204 W. Elm St., Sycamore

James D. Rogers

1230 Scott St., Joliet

Peter Rumore

Effingham

Stanley Ruzich

9944 S. Damen Ave., Chicago

John L. Savage

723 Elm St., Winnetka

V. P. Siegel

4601 State St., East St. Louis

Paul W. Sunderland

Gibson City

Eli Tobias

1469 E. Park Pl., Chicago

Frederick Weiss

15320 Center Ave., Harvey

Lorin D. Whittaker

840 Jefferson Bldg., Peoria

EX-OFFICIO:

J. Ernest Breed

55 E. Washington St., Chicago

Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest
Ted LeBoy
330 Gale Avenue, River Forest
Philip G. Thomsen
13826 Lincoln Ave., Dolton

AUXILIARY REPRESENTATION:

Mrs. Fred C. Endres
229 East Glen Ave., Peoria

STAFF: Clifford Raber

Responsibilities and Purposes

The Public Affairs Committee is concerned with the political process as it pertains to medicine and public health. Within this broad context, appropriate education of the public is basic to continue health improvement in a free society. The electorate must make its wishes known to public officials.

The Public Affairs Committee shall strive to generate interest in the overall field of politics to enable the physician to participate effectively. Programs of public affairs orientation, political education, and campaign characteristics will be undertaken to increase the effectiveness of the physician in public affairs.

MEDICAL ADVISORY COMMITTEE TO THE
ILLINOIS DEPARTMENT OF PUBLIC AID
(Board of Trustees)

Fred A. Tworoger, *Chairman*
9130 Kedvale Ave., Skokie
John H. Steinkamp, *Co-Chairman*
824 Van Buren St., Belvidere
Charles E. Baldree
26 E. Washington St., Belleville
Walter C. Bornemeier
4665 Peterson Ave., Chicago
James R. Cooper
1416 Maine St., Quincy
Chauncey C. Maher, Jr.
709 Myers Bldg., Springfield
Rex O. McMorris
619 N.E. Glen Oak Ave., Peoria
George T. Mitchell
116 S. 5th St., Marshall
Robert C. Muehrcke
518 N. Austin Blvd., Oak Park
Frank B. Norbury
1515 W. Walnut St., Jacksonville
William Scanlon
654—1st St., LaSalle
Frank P. Skaggs
11 E. Poplar St., Harrisburg
R. Kent Swedlund
112 N. Fourth St., Watseka
CONSULTANTS: (to serve on call of the chairman)
Edwin S. Hamilton
151 N. Schuyler St., Kankakee
George F. Lull
400 E. Randolph St., Chicago
Burtis E. Montgomery
37 S. Main St., Harrisburg
STAFF: Walter R. Livingston

Responsibilities and Purposes

The Medical Advisory Committee meets at regular intervals with the staff of the Illinois Department of Public Aid to perform functions necessary to the operation of the medical program under public aid. The committee renders advisory decisions on matters of medical policy in the administration of the quality, quantity, and cost standards of the various public aid programs. The committee operates in conjunction with an established system of county medical advisory committees and serves as a final reviewing body. It provides a channel of communication between physicians and the Department of Public Aid and strives to foster mutual understanding and good relationships.

The committee's functions also include a continuing program of education of physicians to familiarize them with the administrative details of public aid programs.

SUB-COMMITTEE ON ANESTHESIOLOGY

James A. Felts, *Chairman*
517 Bainbridge Rd., Marion
James H. Rutledge
226 S. Monroc St., Pittsfield
Max S. Sadove
840 S. Wood St., Chicago
Arthur T. Shima
532 N. Oak Park Ave., Oak Park
C. H. Walton
602 W. University Ave., Urbana

SUB-COMMITTEE ON CARDIOVASCULAR DISEASE

Robert Page, *Chairman*
950 E. 59th St., Chicago
Richard A. Wall
2755 W. 15th Pl., Chicago
William S. Dye
25 E. Washington St., Chicago
F. John Lewis
303 E. Superior St., Chicago
Peter V. Moulder
950 E. 59th St., Chicago

SUB-COMMITTEE ON OPHTHALMOLOGY

Leo P. A. Sweeney, *Chairman*
10725 S. Western Ave., Chicago
Max Hirschfelder
Box 529, Centralia
Derrick Vail
700 N. Michigan Ave., Chicago

SUB-COMMITTEE ON RADIOLOGY

John H. Gilmore, *Chairman*
1012 Bonita Dr., Park Ridge
Fred H. Decker
221 N.E. Glen Oak Ave., Peoria
George E. Irwin, Jr.
703 N. East St., Bloomington
Wilson Scott
1400 Taylor Dr., Carbondale
L. S. Tichy
5401 Cornell Ave., Chicago
STAFF: Walter R. Livingston

Responsibilities and Purposes

The sub-committees function under the aegis of the Medical Advisory Committee in rendering specialized advice to the staff of the Illinois Department of Public Aid. Consultation from individual members is generally sought by telephone or letter regarding services to specific patients. All matters affecting changes in policy should be coordinated with the Medical Advisory Committee.

COMMITTEE ON PUBLIC RELATIONS

(Bylaws)

Term
Expires

Leo P. A. Sweeney, <i>Chairman</i>	
10725 S. Western Ave., Chicago	1967
Andrew J. Brislen	
6060 Drexel Blvd., Chicago	1968
Matthew B. Eisele	
4601 State St., East St. Louis	1967
Charles J. Weigel	
7579 Lake St., River Forest	1966
Lee F. Winkler	
850 S. 4th Ave., Springfield	1968

Ex-Officio:

Jacob E. Reisch
1129 S. 2nd St., Springfield

STAFF: James Slawny

*Responsibilities and Purposes Described in
Constitution and Bylaws*

RADIO-TELEVISION SUB-COMMITTEE

Leo P. A. Sweeney, *Chairman*
10725 S. Western Ave., Chicago
Max Klinghoffer
127 E. Vallette, Elmhurst
Bertram B. Moss
5360 N. Lincoln, Chicago

SUB-COMMITTEE ON VOLUNTARY HEALTH AGENCIES

Andrew J. Brislen, *Chairman*
Matthew B. Eisele
Edward A. Piszczeck
6410 Leona Ave., Chicago

SUB-COMMITTEE ON COMMUNITY HEALTH WEEK

Matthew B. Eisele, *Chairman*
Andrew J. Brislen
Edward A. Piszczeck

SUB-COMMITTEE ON NEWSPAPERS

Charles J. Weigel, *Chairman*
Donald Miller
6626 N. Sauganash Ave., Lincolnwood

SUB-COMMITTEE ON SPECIAL PROMOTIONS

Lee Winkler, *Chairman*
Jacob Reisch

COMMITTEE ON PUBLIC SAFETY

(Bylaws)

Term
Expires

Julius M. Kowalski, <i>Chairman</i>	
436 Park Ave. East, Princeton	1967

Clarence E. Cawvey	
206 N. Main St., Pinckneyville	1968
George H. Irwin	
1791 Howard St., Chicago	1967
Edwin A. Lee	
501 S. 13th St., Springfield	1966
Norman J. Rose	
500 State Office Bldg., Springfield	1966
Clifford P. Sullivan	
8000 S. Racine Ave., Chicago	1966

AUXILIARY REPRESENTATION:

Mrs. Joseph Shanks
3121 Sheridan Road, Chicago

STAFF: James Slawny

*Responsibilities and Purposes Described in
Constitution and Bylaws*

SUB-COMMITTEE ON TRAUMA

George H. Irwin, *Chairman*
1791 Howard St., Chicago
James J. Callahan
4849 Fullerton Ave., Chicago
James P. Campbell
322 N. Blanchard St., Wheaton

SUB-COMMITTEE ON PEDIATRIC HAZARDS

Clifford P. Sullivan, *Chairman*
Norman J. Rose

SUB-COMMITTEE ON PUBLIC HEALTH

Edwin A. Lee, *Chairman*
Franklin D. Yoder
503 State Office Bldg., Springfield
Edward Press
Room 1827, 160 N. LaSalle St., Chicago

COMMITTEE ON QUACKERY

(Board of Trustees)

Frank H. Fowler, *Chairman*
6356 Diversey Ave., Chicago

George F. Lull
400 E. Randolph St., Chicago

Edward A. Piszczeck
6410 N. Leona Ave., Chicago

Ex-Officio:

Oliver Field
535 N. Dearborn St., Chicago
John W. Neal
310 S. Michigan Ave., Chicago

STAFF: John W. Neal

Responsibilities and Purposes

The Committee on Quackery shall concern itself with the illegal practice of medicine and other healing arts groups associated with unfounded claims for cure of disease. It shall cooperate with the legal authorities of the State, such as the office of the Attorney General, in providing information and witnesses for the prosecution of violators of the law. It shall cooperate with the American Medical Association's Department of Investigation, and other agencies interested in this field.

COMMITTEE ON RADIATION

(Board of Trustees)

Howard C. Burkhead, *Chairman*
Evanston Hospital Association,
2650 Ridge Ave., Evanston

Abram H. Cannon
194 Michael John Dr., Park Ridge

Stephen L. Casper
1101 Maine St., Quincy

James A. Crilly
4601 State St., East St. Louis

Fred H. Decker
221 N.E. Glen Oak, Peoria

Robert W. Donnelly
812 N. Logan Ave., Danville

Harvey White
400 Ashland Ave., Evanston

Raymond B. White
9333 S. Damen Ave., Chicago

EX-OFFICIO:

J. Ernest Breed
55 E. Washington St., Chicago

Carl E. Clark
225 Edward St., Sycamore

CONSULTANT:

Robert S. Landauer, Ph.D.
1360 N. Lake Shore Dr., Chicago

STAFF: Albert G. Boeck

Responsibilities and Purposes

The committee shall serve as a source of information on radiation matters for ISMS and evaluate available information and make recommendations to the Board for the position ISMS should take on issues in this area. It shall cooperate with institutions and voluntary health agencies in disseminating information on radiation subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correcting for the protection of the public.

LIAISON COMMITTEE TO ILLINOIS DEPARTMENT OF REGISTRATION AND EDUCATION (Board of Trustees)

Jacob E. Reisch, *Chairman*
1129 S. Second St., Springfield

H. Close Hesseltine
5841 S. Maryland Ave., Chicago

Edward A. Piszezczek
6410 N. Leona Ave., Chicago

STAFF: Paul S. Swarts

Responsibilities and Purposes

This committee was formed at the request of the Director of the Department of Registration and Education of the State of Illinois, and shall consider problems of mutual concern in the area of the licensing of physicians.

COMMITTEE ON REHABILITATION SERVICES (Board of Trustees)

Edward L. Compere, *Chairman*
720 N. Michigan Ave., Chicago

Paul Richard Allyn
709 Myers Bldg., Springfield

Henry B. Betts
1511 N. State Pkwy., Chicago

Eli Borkon
Carbondale Clinic, Carbondale

Rex O. McMorris
619 N.E. Glen Oak Ave., Peoria

Robert Dunham Moore
950 E. 59th St., Chicago

Daniel Ruge
700 N. Michigan Ave., Chicago

Howard W. Schneider
238 W. 154th St., Harvey

CONSULTANT:

Reuben R. Wasserman
820 S. Damen Ave., Chicago

EX-OFFICIO:

Frank J. Jirka
1507 Keystone Ave., River Forest

STAFF: Walter R. Livingston

Responsibilities and Purposes

The purposes of the Committee on Rehabilitation Services are to provide liaison between the Illinois State Medical Society and the Division of Vocational Rehabilitation, the Department of Public Aid, and other official or non-official agencies which purchase rehabilitation care for patients. The committee also works closely with the Governor's Committee on Employment of the Handicapped when called upon for its advice and counsel.

The committee shall render assistance to public and private agencies in the establishment of policies regarding rehabilitation facilities to be used and selection of patients for these services; encourage the training of rehabilitation personnel, thereby promulgating high quality care; and assist when possible to see that adequate medically supervised rehabilitation services be made available in all hospitals, according to the need of the hospital.

COMMITTEE ON RELATIVE VALUE (Board of Trustees)

C. Elliott Bell, *Chairman*
964 Citizens Bldg., Decatur

Walter C. Bornemeier
4665 Peterson Ave., Chicago

John F. Eggers
111 W. Elm St., Sycamore

F. Gregory Green
1355 Charles St., Rockford

Gershom K. Greening
701 N. Walnut St., Springfield

Joseph G. Gustafson
1508 Seventh Street, Moline

Franklin J. Moore
55 E. Washington St., Chicago

Max S. Sadove
840 S. Wood St., Chicago

Theodore J. Wachowski
310 Ellis Ave., Wheaton

STAFF: Walter R. Livingston

Responsibilities and Purposes

The functions of this committee shall include the responsibility for professional education on the uses of the Relative Value Study; the distribution of the study upon request; and the revision of the Relative Value Study at appropriate intervals to keep it up to date.

COMMITTEE ON RELIGION AND MEDICINE (Board of Trustees)

Joseph R. Mallory, *Chairman*
The Link Clinic, Mattoon

Eli L. Borkon
Carbondale Clinic, Carbondale

Charles W. Pfister
5511 N. Harlem Ave., Chicago

Paul S. Rhoads
251 E. Chicago Ave., Chicago

EX-OFFICIO:
J. Ernest Breed
55 E. Washington St., Chicago

Caesar Portes
25 E. Washington St., Chicago

AUXILIARY REPRESENTATION:
Mrs. Wendell F. Roller
703 E. 2nd Ave., Mommouth

STAFF: James Slawny

Responsibilities and Purposes

The committee is responsible for the development of effective lines of communication between the physicians and the clergymen leading to the most effective care and treatment of the patient and his family.

RURAL HEALTH AND STUDENT LOAN FUND (Board of Trustees)

Jack L. Gibbs, *Chairman*
24 Main St., Canton

Thomas C. Bunting
321 W. Washington, Pittsfield

Jacob E. Reisch
1129 S. Second St., Springfield

STAFF: James Slawny

Responsibilities and Purposes

The committee shall be responsible to the Board of Trustees in matters related to improving the standards of health in rural areas and with administration of the Student Loan Program operated jointly with the Illinois Agricultural Association. Members of the committee shall be appointed by the Board for terms of one year. The committee shall work closely with the Illinois Agricultural Association in efforts to improve the standard of health in farm areas. Also among these responsibilities is to induce physicians to practice in rural areas through the joint program with the Illinois Agricultural Association.

COMMITTEE ON SCIENTIFIC ASSEMBLY (Bylaws)

	Term Expires
Robert T. Fox, <i>Chairman</i> 2136 Robin Crest Ln., Glenview	1968
Richard A. DeWall 2755 W. 15th St., Chicago	1967
Robert R. Fahringer 1230 S. 6th St., Springfield	1968
Charles P. McCartney 5841 S. Maryland Ave., Chicago	1966
Harold McGinnis 2304 E. Oakland Ave., Bloomington	1967
Robert G. Page 950 E. 59th St., Chicago	1967
Gordon L. Snider 7936 S. Luella Ave., Chicago	1966
J. Robert Thompson 1129 N. Elmwood Ave., Oak Park	1966
Donald L. Unger 185 N. Wabash Ave., Chicago	1968
EX-OFFICIO:	
William M. Lees 7000 N. Kenton Ave., Lincolnwood	
AUXILIARY REPRESENTATION:	
Mrs. Robert E. Field 13004 S. Greenwood Ave., Blue Island	
Mrs. Maurice Goldstein 6853 N. Hiawatha Ave., Chicago	
STAFF: Albert G. Boeck, Jr.	

COMMITTEE ON SCIENTIFIC EXHIBITS
(Board of Trustees)

Coye C. Mason, *Chairman*
2052 N. Orleans, Chicago
Raymond Firfer
7330 Cortland, Elmwood Park
Charles P. McCartney
5841 S. Maryland Ave., Chicago
W. H. Newcomb
316 W. State St., Jacksonville
L. W. Peterson
929 Michigan Ave., Wilmette
Arkell M. Vaughn
2015 E. 79th St., Chicago
Leo M. Zimmerman
55 E. Washington St., Chicago
STAFF: Albert G. Boeck

Responsibilities and Purposes

This committee shall function with the Committee on Scientific Assembly to establish the qualifications, standards and regulations affecting scientific exhibitors at the annual convention; it shall solicit scientific exhibits of current medical interest, and select those most suitable for the ISMS convention.

ADVISORY COMMITTEE TO SECRETARIES' CONFERENCE
(Board of Trustees)

Emil R. Zidek, *Chairman*
2236 Haddon St., Chicago
William T. Couter, *Vice-Chairman*
1314 N. Main St., Decatur
Joseph J. Grandone, *Secretary*
109 W. Pine St., Gillespie
EX-OFFICIO:
Jacob E. Reisch
1129 S. Second St., Springfield
STAFF: Roland I. King

Responsibilities and Purposes

The responsibilities of this committee have been established as follows: ". . . plan and develop programs for an annual meeting of county medical society secretaries. Its duties shall include the development of procedures by which the Society's headquarters can render better and more efficient service to county societies, and county societies to their own membership."

ADVISORY COMMITTEE TO STUDENT A.M.A.

Maurice M. Hoeltgen, *Chairman*
Stritch School of Medicine—Loyola
706 S. Wolcott Ave., Chicago
Hilger Perry Jenkins
University of Chicago School of Medicine
950 E. 59th St., Chicago
Louis R. Limarzi
University of Illinois College of Medicine
1853 W. Polk St., Chicago

Ralph E. Dolkart
Northwestern University Medical School
303 E. Chicago Ave., Chicago
David B. Radner
Chicago Medical School
710 S. Wolcott Ave., Chicago
STAFF: James Slawny

Responsibilities and Purposes

The committee is charged with the responsibility of maintaining liaison with officers of Student AMA Chapters in Illinois; establishing programs to acquaint medical students with the principles of organized medicine; and developing programs designed to advance the purposes of both organizations.

COMMITTEE ON TUBERCULOSIS
(Board of Trustees)

Charles K. Petter, *Chairman*
2400 Belvidere St., Waukegan
Otto L. Bettag
526 Crescent Blvd., Glen Ellyn
Kenneth G. Bulley
1329 N. Lake St., Aurora
Clifton F. Hall
1517 Noble Ave., Springfield
Charles A. Lang
202 Ellis, Wheaton
Hiram Thomas Langston
1919 W. Taylor St., Chicago
David F. Loewen
400 W. Hay St., Decatur
Karl H. Pfuetze
Suburban Cook County Sanitarium
55th St. and County Line Rd., Hinsdale
George C. Turner
6627 Ponchartrain Blvd., Chicago

EX-OFFICIO:

William E. Adams
950 E. 59th St., Chicago
Edward A. Piszczek
6410 N. Leona Ave., Chicago
Darrell H. Trumpe
St. John's Sanatorium, Springfield

STAFF: Albert G. Boeck

Responsibilities and Purposes

This committee shall serve as a source of information on tuberculosis matters for the ISMS, and evaluate available information and make recommendations to the Board for the position the ISMS should take on issues in this area. It shall cooperate with institutions and voluntary health agencies in disseminating information on tuberculosis subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Caesar Portes, *Chairman (President-Elect)*
25 E. Washington St., Chicago
Burtis E. Montgomery (*President*)
37 S. Main St., Harrisburg
William E. Adams (*Chairman of the Board*)
950 E. 59th St., Chicago
Ex-OFFICIO: Robert L. Richards
STAFF: Robert L. Richards

Responsibilities and Purposes

The Advisory Committee to the Woman's Auxiliary shall consist of the President-Elect as chairman, the President, the Chairman of the Board.

The committee shall provide advice and assistance to the President of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the State Medical Society to the Auxiliary members.

TRUSTEE DISTRICT COMMITTEES

First District

Carl E. Clark, Sycamore, *Trustee*.
Counties of Boone, Carroll, DeKalb, JoDavies,
Kane, Lake, McHenry, Ogle, Stephenson, Winne-
bago

Term
Expires

ETHICAL RELATIONS COMMITTEE

John W. Ovitz, *Chairman*, Sycamore.....1968
E. J. McKinney, 2300 N. Rockton,
Rockford1966
Benjamin F. Shirer, 4 W. Wilson St.,
Batavia1967
John H. Steinkamp, Belvidere.....1966

GRIEVANCE COMMITTEE

Russel Zack, *Chairman*, Medical-Dental Bldg.,
Rochelle1967
A. K. Matthews, 1401 E. State St., Rockford..1966
M. Mijanovich, Marengo.....1968
Walter J. Reedy, 814 Washington St.,
Waukegan1966

PREPAYMENT PLANS & ORGANIZATIONS

Delbert O. Williams, Jr., *Chairman*, Stockton.1968
George B. Callahan, 4 S. Genesee St.,
Waukegan1967
R. E. Whitsitt, 5535 N. 2nd, Rockford.....1966

Second District

Ralph N. Redmond, Sterling, *Trustee*.
Counties of Bureau, LaSalle, Lee, Livingston, Mar-
shall, Putnam, Whiteside, Woodford

ETHICAL RELATIONS COMMITTEE

Dexter Nelson, *Chairman*, Princeton.....1968
Ralph Bailey, Ottawa.....1966
Tim Sullivan, Sterling.....1967

GRIEVANCE COMMITTEE

Edward Murphy, *Chairman*, Dixon.....1968
Francis J. Brennan, Utica.....1967
K. M. Nelson, Princeton.....1966

PREPAYMENT PLANS & ORGANIZATIONS

Perry V. Hartman, *Chairman*, Granville.....1968
M. D. Burnstine, Sterling.....1967
Joseph Phifer, Eureka.....1966

Third District

William E. Adams, Chicago
J. Ernest Breed, Chicago
Frank J. Jirka, River Forest

Ted LeBoy, River Forest
William M. Lees, Lincolnwood
Philip Thomsen, Dolton
No district committees are appointed

Fourth District

Paul P. Youngberg, Moline, *Trustee*.
Counties of Fulton, Hancock, Henderson, Henry,
Knox, McDonough, Mercer, Peoria, Rock Island,
Schuyler, Stark, Warren

ETHICAL RELATIONS COMMITTEE

Paul Schmidt, *Chairman*, Galva.....1966
John Bowman, Abdingdon.....1967
Richard Icenogle, Roseville.....1968

GRIEVANCE COMMITTEE

F. A. Christensen, *Chairman*,
First Nat'l Bank Bldg., Peoria.....1966
Russell Jensen, Monmouth.....1967
Elliott Parker, 1630—5th Ave., Moline.....1968

PREPAYMENT PLANS & ORGANIZATIONS

A. W. Wellstein, *Chairman*, Geneseo.....1966
Donald Dexter, Macomb.....1968
Richard Terry, Kewanee.....1967

Fifth District

Darrell H. Trumpe, Springfield, *Trustee*.
Counties of DeWitt, Logan, McLean, Mason, Men-
ard, Montgomery, Sangamon, Tazewell

ETHICAL RELATIONS COMMITTEE

Herman L. Meltzer, *Chairman*,
301 W. Washington, Clinton.....1966
Arthur Conklin, 219 N. Main St.,
Bloomington1967
William W. Curtis, 100 W. Miller, Springfield.1968

GRIEVANCE COMMITTEE

Clifford Draper, *Chairman*, Hillsboro.....1966
Lee N. Hamm, 113 S. Pine St., Lincoln.....1968
A. J. Morris, 701 N. Walnut St., Springfield..1967

PREPAYMENT PLANS & ORGANIZATIONS

J. G. Meyer, Jr., *Chairman*,
413 W. Monroe St., Springfield.....1966
Robert B. Perry, 315 Broadway, Lincoln.....1967
Robert Price, 216 E. Washington,
Bloomington1968

Sixth District

Newton DuPuy, Quincy, *Trustee*.
Counties of Adams, Brown, Calhoun, Cass, Greene,

Jersey, Macoupin, Madison, Morgan, Pike, Scott

ETHICAL RELATIONS COMMITTEE

Leo R. Green, *Chairman*,
1114 Milton Rd., Alton.....1966
Bernard Baalman, Hardin.....1968
J. Mather Pfeifferberger, 1st Nat'l Bank,
Alton1967

GRIEVANCE COMMITTEE

Robert R. Hartman, *Chairman*,
316 W. State St., Jacksonville.....1966
Edward K. DuVivier, 1900 Brown St., Alton..1968
Robert C. Murphy, 1416 Maine St., Quincy...1967

PREPAYMENT PLANS & ORGANIZATIONS

E. C. Bone, *Chairman*,
800 W. State St., Jacksonville.....1967
J. Richard Cooper, 1416 Maine St., Quincy...1966
Paul A. Dailey, 620 N. Main St., Carrollton...1968
Harry Mantz, 604 E. Broadway, Alton.....1966

Seventh District

Arthur F. Goodyear, Decatur, *Trustee*.
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

ETHICAL RELATIONS COMMITTEE

Kenneth Pistorius, *Chairman*, Moweaqua...1967
Max Hirschfelder, Centralia.....1968
E. H. Rames, Vandalia.....1966

GRIEVANCE COMMITTEE

Edgar Wier, *Chairman*, Altwood.....1967
Boyd McCracken, Greenville.....1968
William Sargent, Effingham.....1966

PREPAYMENT PLANS & ORGANIZATIONS

Philip Lynch, *Chairman*,
1315 N. Main St., Decatur.....1966
Richard Larson, Shelbyville.....1968
Peter Rumore, Effingham.....1967

Eighth District

William H. Schowengerdt, Champaign, *Trustee*.
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

ETHICAL RELATIONS COMMITTEE

Mack W. Hollowell, *Chairman*,
35 Circle Dr., Charleston.....1968
Myron I. Boylson, 403 S. Court, Tuscola.....1967
E. A. Fahnstock, Bridgeport.....1966

GRIEVANCE COMMITTEE

A. R. Brandenberger, *Chairman*,
605 N. Logan Ave., Danville.....1968
Gordon Sprague, Paris.....1967
L. M. T. Stilwell, 510 E. Daniel St.,
Champaign1966

PREPAYMENT PLANS & ORGANIZATIONS

James W. Landis, *Chairman*, Olney.....1968
N. L. Brookens, 602 W. University Ave.,
Urbana1966
E. A. Kendall, Mattoon.....1967
George T. Mitchell, 116 S. 5th St., Marshall...1966

Ninth District

Charles K. Wells, Mt. Vernon, *Trustee*.
Counties of Edwards, Franklin, Gallatin, Hamilton, Hardin, Jefferson, Johnson, Massac, Pope, Saline, Wabash, Wayne, White, Williamson

ETHICAL RELATIONS COMMITTEE

G. R. Johnson, *Chairman*, Harrisburg.....1968
John P. Pope, Benton.....1966
N. A. Thompson, Eldorado.....1967

GRIEVANCE COMMITTEE

C. J. Jannings, *Chairman*, Fairfield.....1967
Herbert Fine, Carterville.....1966
Herman Rogers, TB Sanitarium, Mt. Vernon..1968

PREPAYMENT PLANS & ORGANIZATIONS

Denton Ferrell, *Chairman*, Eldorado.....1968
H. L. Lewis, Benton.....1967
E. A. Veach, Vienna.....1966

Tenth District

Willard C. Scrivner, East St. Louis, *Trustee*.
Counties of Alexander, Jackson, Monroe, Perry, Pulaski, Randolph, St. Clair, Union, Washington

ETHICAL RELATIONS COMMITTEE

William Borgsmiller, *Chairman*, Murphysboro.1966
Harold E. McCann, 2720 State St.,
East St. Louis.....1968
A. L. Robinson, Mounds.....1967

GRIEVANCE COMMITTEE

R. E. Matlavish, *Chairman*, DuQuoin.....1967
William H. Walton, 109 S. High St.,
Belleville1966
William H. Whiting, Anna.....1968

PREPAYMENT PLANS & ORGANIZATIONS

R. W. Jost, *Chairman*, 107 E. 4th St.,
Waterloo1966
R. E. Schettler, Red Bud.....1968
James A. Weatherly, Murphysboro.....1967

Eleventh District

Joseph R. O'Donnell, Glen Ellyn, *Trustee*.
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will

ETHICAL RELATIONS COMMITTEE

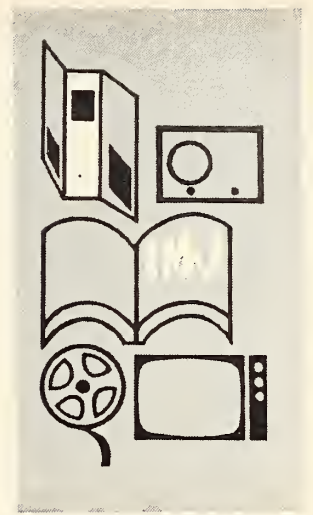
Donald A. Meier, *Chairman*,
555 S. Schuyler Ave., Kankakee.....1968
Leonard F. Roblee, Lockport.....1967
Paul W. Sunderland, 214 N. Sangamon,
Gibson City1968

GRIEVANCE COMMITTEE

Lloyd W. Jessen, *Chairman*, Peotone.....1966
Morgan M. Meyer, Lombard.....1967
R. Kent Swedlund, Watseka.....1968

PREPAYMENT PLANS & ORGANIZATIONS

J. P. Schweitzer, *Chairman*, Oak Brook
Professional Bldg., Oak Brook.....1966
Charles Allison, 1309 E. Court St., Kankakee..1966
J. M. Stoker, 172 Schiller, Elmhurst.....1968
George H. Woodruff, 250 N. Ottawa St.,
Joliet1967



ISMS SERVICES

Pursuit of Obligations

PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to elevate the standards of medical education
- to unite the medical profession behind these purposes, and
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 360 N. Michigan Ave., Chicago, and an office in Springfield at 520 S. Sixth St. Services of the Society, under the general su-

pervision of Robert L. Richards, Executive Administrator, are conducted by the following divisions, each of which is headed by a staff director:

Administration; Business Services; Economics and Insurance; Legislation and Public Affairs, and Publications and Scientific Services.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors, and still others are sponsored for specific groups or individuals.

Following are descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters; the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

In order to provide the membership of the Society with the best professional staff services available, headquarters has been set up by divisions. The Division of Administration (which the Administrator directs personally) provides many important functions.

This Division develops liaison with the Board of Trustees and serves the chairman in carrying out his duties. It works closely with the speaker of the House of Delegates and the officers of the Society to provide a smooth and efficient atmosphere in which the House may function.

The controlling factor in all these areas is the Constitution and Bylaws. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action.

The Division, through the Administrator, channels all legal inquiries and works with the General Legal Counsel and the Special Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

The duties and powers of the Executive Administrator are of utmost importance, and are outlined in the Bylaws of the Society.

DIVISION OF BUSINESS SERVICES

Just as the entire staff of the Illinois State Medical Society exists to serve the needs of more than 10,000 members, the Division of Business Services exists to serve the needs of the other staff divisions. Specifically, all mail room, printing, duplicating, and central-supply services are provided by this division.

Membership Records

Membership records are maintained so that quick access may be had to correct information concerning the basic membership history of each of our members. In addition, forms to obtain dues, address changes and other necessary information are designed and supplied to each county society secretary for their use.

The Committees on Membership and the Annual Secretaries' Conference are assigned to this division for the staff services which might be required. The Committee on Membership has been dealing with the on-going problem of sound membership development. The Advisory Committee to the Annual Secretaries' Conference has the responsibility for developing an enlightening program which will help county secretaries find better ways to serve

both the public and their county society membership more effectively.

Accounting and Budget

Responsibility for providing safekeeping and proper accounting for all money and securities of the Society rests with this division, upon the direction and guidance of the Board of Trustees Finance Committee, the Secretary-Treasurer, and the Executive Administrator. Assistance is offered to all interested staff and officers in the interpretation of the division's regular and special accounting and budgetary reports.

Liaison with outside agencies in regard to matters affecting the finances of the Society is a prime responsibility of this division; the Internal Revenue Service, the Society's banking and investment agencies, office building rental agent, and the American Medical Association are major examples.

Insurance Coverage

Provision for and maintenance of the Society's property, liability, and employee insurance coverages are handled within this division, so that legal and financial requirements are satisfied at the most economical premium cost. In this area of responsibility, the assistance and cooperation of the Division of Economics and Insurance are utilized in order that best results for the Society may be obtained.

Standardization of office procedures and systems in order to reduce the cost and raise the efficiency of the office operation is a continuing assignment for the division. Assistance in personnel recruitment, job analysis, and salary range administration is provided to the Executive Administrator and other division directors.

DIVISION OF ECONOMICS AND INSURANCE

The Division of Economics and Insurance is responsible for supplying a wide variety of information on economic topics and insurance data to members of the Illinois State Medical Society. The division is frequently called upon to prepare speeches, write and publish pamphlets and other materials and make them available for distribution on such subjects as Kerr-Mills medical care in Illinois, medical care financing through Social Security, and physician retirement programs.

The division, so far as it is possible to do so, designs and directs research in the area of economics. Such projects have included the Relative Value Survey and the Social Security poll.

Reference Library

A library providing a reference source for membership and staff use is maintained. Information is available on the cost of medical care; foreign medical care systems; needs and wants of the aged, their medical care, housing, health, finances and employment; and the Social Security system, its benefits, costs, financing, and coverage.

The division also provides information on matters pertaining to group insurance and retirement plans for the members of the state medical society and administrative staff. Periodically information is prepared for physicians and the public pertaining to such medical care programs as Assistance to the Medically Indigent Aged, Old Age Assistance, Aid to the Medically Indigent, and the Military Dependents' Medical Care (Medicare).

Public Aid Liaison

Familiarity with the medical care programs of the Illinois Department of Public Aid and liaison with the staff of the department are other responsibilities of the division. Liaison is also maintained with public and private agencies interested in the fields of aging, insurance, hospitals, and rehabilitation.

The division provides staff services to committees involved in economics, fee schedules, aging, prepayment plans, insurance, rehabilitation, hospitals, medical care programs through public aid, state and government programs of medical care, the accreditation of hospitals and nursing homes.

DIVISION OF PUBLIC RELATIONS

The Public Relations Division normally serves as the Society's source of information, or news outlet, to the lay press, radio and television. With increasing frequency, the division is contacted by news reporters, science writers and authors seeking to verify the accuracy of a report. Its counseling services on public relations and publicity are available to any county medical society.

A mailing list of all newspapers, radio and television stations in Illinois is maintained by the division. The list is so arranged that news releases may be addressed to individual counties, and county society secretaries may avail themselves of this service.

News releases for county societies are automatically prepared by the division staff and distributed to all news outlets in the particular county whenever a county society makes use of the ISMS postgraduate education program. Other than this, the state society's staff does not prepare news releases of county society activities unless this service is specifically requested.

Health Columns for Newspapers

Currently, ISMS presents a weekly public service health column entitled "Dr. 'SIMS' Says: Safeguard Your Health." This column, offered to the 650 newspapers in Illinois, carries a new logotype of Dr. "SIMS" which readily identifies the column with the Illinois State Medical Society. The division would appreciate hearing from members in areas where the column is not appearing.

Pamphlets Available

As a vital part of the continuing "positive public relations" programs of the ISMS, pamphlets on a variety of health subjects are available to the coun-

ty medical societies for the asking. Doctors should have these pamphlets in their waiting rooms. Attractive pamphlet racks with literature are available at a cost of only one dollar each by writing to this division.

Other materials available from the Public Relations Division are described on the following pages. These materials include exhibits, radio-television programs, disaster hospital manuals, medical career recruitment materials, speakers' bureau information, and films.

Committees of the Society serviced by the Public Relations Division are Disaster Medical Care, Ethical Relations, Fifty-Year Club, Grievance, Medicine and Religion, Medical Assistants, Public Relations, Public Safety, Rural Health and Student Loan Fund, and the Advisory Committee to Student AMA Chapters.

DIVISION OF PUBLICATIONS AND SCIENTIFIC SERVICES

All publications of the Society, including the *Illinois Medical Journal*, are produced through this division. The Journal, the official publication of the Society, is mailed monthly to all members, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state. The editor welcomes suggestions for articles which may be of special interest to members.

Committee Responsibilities

Services to 20 scientific committees are provided by this division. These committees, made up of physicians, provide guidance to the Board of Trustees and House of Delegates in areas of special medical interest. They make recommendations for policy and programs involved in cancer, cardiovascular disease, eye health, environmental health, child health, mental health, nursing, nutrition, radiation safety, medical education and tuberculosis. Others study the problem of maternal welfare and perinatal mortality in cooperation with the State Department of Public Health.

Staff members of the division coordinate and implement the activities of the Committee on Continuing Education to provide scientific programs for district and county medical society meetings.

Annual Convention

Similarly, the staff serves as an arm of the Committee on Scientific Assembly to arrange and produce the annual convention of ISMS. Held in May in Chicago each year, the convention offers scientific meetings and exhibits as well as sessions of the House of Delegates.

A new function of the division is to administer the affairs of the Educational and Scientific Foundation, a non-profit organization established to conduct educational and scientific projects related to medicine. Physicians are invited to become Fellows of the Foundation for a charter membership of \$100.

DIVISION OF LEGISLATION AND PUBLIC AFFAIRS

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically related pieces of legislation.

The ISMS Legislative Committee acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a

meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. This program, executed by the Division of Legislation and Public Affairs, as directed by the ISMS Public Affairs Committee, strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

Impartial Medical Testimony

The Division also performs medical-legal interactions common to the programs assigned. One of these, involving medicine, law, and the judiciary, is the administration of the Impartial Medical Testimony program. This medical service program, operating in conjunction with the Supreme Court of Illinois, provides the services of impartial medical examiners as ordered by the Circuit Courts of Illinois in personal injury cases.

Other facets of medical-legal interaction are explored and problems resolved through liaison with like committees of the judiciary and the bar associations.

In addition to the foregoing, special and ongoing programs and activities of the Archives Committee, Benevolence Committee, Committee on Occupational Health, and Committee on Narcotics and Hazardous Substances; Advisory Committee to the Department of Registration and Education and the Committee on Laboratory Evaluation are administered.

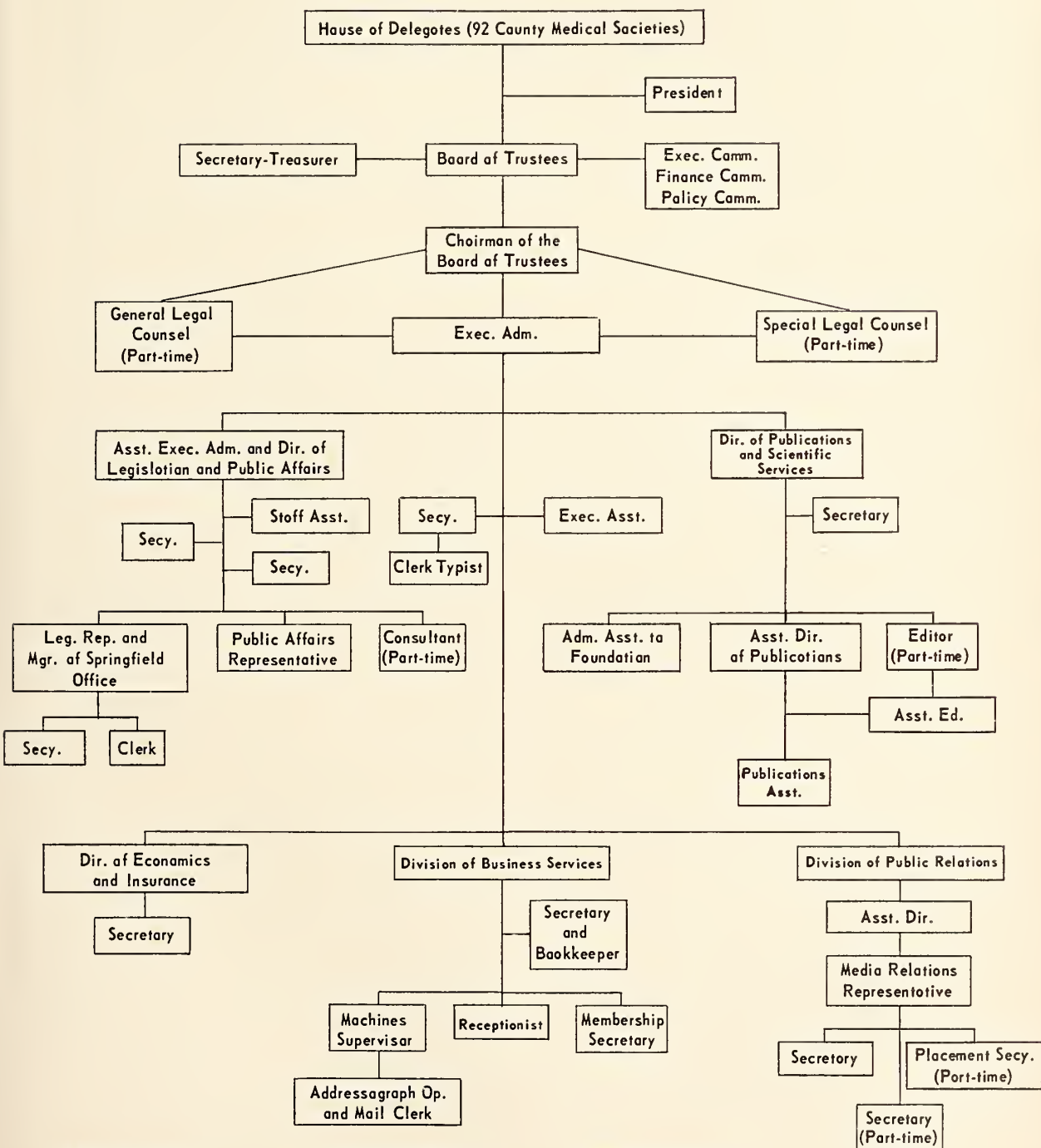
THE EDUCATIONAL & SCIENTIFIC FOUNDATION

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of medical science through:

- 1) The initiation of scientific and medical research activities.
- 2) The collection, evaluation and dissemination of the results of research activities to the public.
- 3) The implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge.

ISMS STAFF ORGANIZATIONAL CHART

(As of January 1, 1965)



29 Full-time Employees

1 Foundation Employee

6 Part-time Employees

Radio-TV Public Service Materials

Radio materials available from the Illinois State Medical Society include:

- 1) "Today's Health Tip"—a new 30-second health message every day. Available on records (30 messages per record) which feature the voice of Dr. "SIMS." For added local appeal, scripts are also available which can be read by local announcer or physician.
- 2) "Medical Interview"—a five minute weekly interview series featuring a different doctor each week, discussing subjects on practical health matters in language the layman can understand.

Television materials currently include one-minute animated spots on the subjects of measles and rheumatic fever. Subsequent spots stressing preventive medicine will be produced during the course of the year.

In addition, the Division of Public Relations maintains a radio and television speakers' bureau, which obtains physician-speakers for radio and television interview shows on request.

County Medical Society Speakers' Bureau

The Illinois State Medical Society recognizes that one of the prime responsibilities of the medical profession is to maintain and improve good relations with the public. For that reason it encourages county medical societies to set up speakers' bureaus to supply physician speakers to interested lay groups in the area.

The Public Relations Division of ISMS has prepared a comprehensive instructional guide entitled, "How to Set Up a Speakers' Bureau," to help county societies communicate with the public. The booklet, available from the Society without charge, includes information on speakers' rosters, suggested audiences, and publicity helps.

Medical Self-Help Training Program

The Disaster Medical Care Committee of the Illinois State Medical Society strongly endorses the training of at least one person in each family on procedures to follow in the event of a medical emergency. This would be of value not only in the event of an atomic disaster, when physicians would not be available, but also in caring for other emergencies until the help of a physician can be obtained.

For this reason the Society presented "Medical Self Help Training" as an official television course over educational Channel 11 in Chicago early in 1964 and again in 1965. Over 10,000 persons enrolled in this course. Response was so enthusiastic that films of the complete 15-part, 7½-hour series have been made available to county medical societies, industries, schools, and television stations throughout the state.

For complete information on this film course, as well as a "live" course for group study presenta-

tions, write the Public Relations Division of the state society.

Medicine-Religion Film

The newly formed ISMS Committee on Medicine and Religion has produced a 12-minute color film entitled "Not By Bread Alone." The film, which demonstrates the serious consequences of physicians and clergymen not working together, is intended to stimulate the formation of medicine-religion committees at the county level.

A copy of the film has been sent to each county medical society in the state. Additional copies for showing by other groups are available from ISMS.

Stroke—Early Restorative Measures in Your Hospital

A film, entitled "Stroke—Early Restorative Measures in Your Hospital," produced by the ISMS Committee on Aging, is available from the Society.

Directed toward physicians in all general hospitals, regardless of size, the film illustrates simple and effective methods and devices used in the rehabilitation of stroke patients. It emphasizes the procedures to be instituted immediately upon the patient's admission to the hospital.

Primary purpose of the film is to inform physicians and nurses of the need for immediate action in stroke cases and to interest them in acquiring additional details for treatment through available publications or study courses.

The 20-minute sound, color film illustrates a program of constructive rehabilitation which progresses through three stages: (1) proper positioning, (2) transfer activities and early ambulation, and (3) training for self-care. It indicates how these major steps can be conducted in any hospital, however small, by an interested nurse using a minimum of equipment.

The film may be obtained from the Society on a loan basis for viewing without charge or may be purchased for \$125.

Disaster Hospital Manual

The responsibility of providing immediate medical and hospital care in disasters of any magnitude falls directly on physicians, nurses and hospitals. To aid Illinois communities in developing disaster plans, the ISMS Committee on Disaster Medical Care has adopted a model emergency plan for hospitals.

Originally developed by the Memorial Hospital of DuPage County, Elmhurst, the plan is recognized as a model by the Office of Defense Mobilization in Washington, D. C. Copies are available from the Society.

Impartial Medical Testimony

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth

and facilitate the equitable disposition of personal injury cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is evidence of a wide divergence of medical opinion in the personal injury which is subject to litigation. The introduction of the IMT examiner and subsequent examination of injuries provide the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was established by the introduction of Illinois Supreme Court Rule 17-2 in September 1961. The Rule states, "When in the discretion of a trial court, it appears that an impartial medical examination will materially aid in the just determination of a personal injury case, the court, a reasonable time in advance of the trial, may on its own motion or that of any party, order a physical or mental examination of the party whose mental or physical condition is an issue. The examination shall be made without cost to the parties by a member or members of a panel of physicians chosen for their special qualifications by the Illinois State Medical Society. The court administrator and deputy court administrator are charged with the administration of this Rule.

"A copy of the report of examination shall be given to the court and to the attorneys for the parties. Should the court at any time during the trial find that compelling considerations make it advisable to have an examination and a report at that time, the court may, at its discretion so order. Either party or the court may call the examining physician or physicians to testify, also without cost to the parties. Any physician so called shall be subject to cross-examination. The court shall determine the compensation of the physician or physicians."

Illinois is distinguished in this matter by being the only state which has a court rule permitting the state-wide use of impartial medical testimony. The Illinois State Medical Society played a significant role in the creation and development of the IMT program. Impartial medical testimony in other states is limited to certain jurisdictions within the states.

To implement the IMT rule, the Illinois State Medical Society created a panel of impartial medical examiners. This panel is comprised of approximately 400 physicians who are grouped into 20 medical specialties. These IMT examiners were selected from approximately 4,000 nominated physicians. Composition of the panel is reviewed annually to maintain the highest standards for the courts of Illinois. The IMT examiners are selected from the panel in rotating sequence.

The IMT examiners are paid, on court approval of bills submitted, by the Illinois State Bar Association Foundation, which is the custodian and disbursing agent of a special IMT fund. This fund was made possible by grants from the Ford, Wieboldt, Deere, Woods, and Lilly Foundations.

In a personal injury case, the plan evolves as follows:

- 1) judge invokes Rule 17-2 (when in his judgment introduction of an IMT examiner will aid materially in the equitable disposition of the case);
- 2) judge contacts supreme court administrator, requesting IMT examiner (special forms are used for this purpose);
- 3) court administrator contacts Illinois State Medical Society for IMT examiner, as required by the character of the personal injury;
- 4) ISMS selects an IMT examiner from the panel of the medical specialty relating to the injury involved;
- 5) ISMS relates the identity of the IMT examiner to the court administrator;
- 6) court administrator schedules the examination of the plaintiff, and obtains pertinent medical records for the IMT examiner.
- 7) IMT physician examines plaintiff, and prepares medical report. This report is submitted to the court. Copies are prepared for the attorneys involved.
- 8) IMT examiner is available for court testimony, as required.
- 9) IMT examiner submits bill to the court.
- 10) the IBA Foundation disburses funds to pay for the IMT examiner.

The Illinois State Medical Society is deeply appreciative of its role in offering, in conjunction with the Supreme Court, this impartial medical service for the courts of Illinois. The IMT Committee of the state society is charged with the responsibility of implementing the IMT Rule, as required by the court.

Retirement Investment Program

The Board of Trustees of the Illinois State Medical Society has approved the *Retirement Investment Program* which makes available to members a means of providing for retirement with group advantages an individual physician could not otherwise obtain. The group annuity and mutual fund portion of the program may also be used as funding vehicles for Keogh qualified investment if so desired. The Tax Qualified Retirement Program (Keogh) and the Retirement Investment Program permit balanced investments to counter economic fluctuations.

Annuities or mutual funds alone do not meet the problems of recession and inflation, but together they do permit a sound retirement plan.

The group annuity provides a guaranteed lifetime income at retirement, serving as a hedge against periods of recession or declining prices, while the mutual fund provides an opportunity for common stock investment serving as a hedge against periods of inflation or rising prices.

A member physician wishing this type of retirement protection may obtain it through the Illinois State Medical Society. By doing so he not only

receives advantages he would not otherwise have but he is able to benefit from the collective opinions and research facilities of the insurance company and the mutual fund's investment advisor.

The *Retirement Investment Plan*, making available the group annuity at a substantial reduction in premium, and the mutual fund, offered without sales commission load, is one of the most recent of its kind and was developed after several years of study taking into consideration other group plans and retirement alternatives.

The size of the retirement contribution, the proportion of investment between the group annuity and the mutual fund, and the retirement age are determined by the participating physician.

The Continental Illinois National Bank and Trust Co. of Chicago receives all physicians' contributions, and maintains records.

Group Annuity

The group annuity, underwritten by the Continental Assurance Co., participates in dividends which are reinvested annually at compound interest.

The group annuity may provide an insurance death benefit and a total and permanent disability guarantee. In the event of death prior to retirement, a member's beneficiary would receive the death benefit or the cash value of the annuity whichever is greater.

Six options for settlement at retirement are available under the annuity. The most frequently chosen is the life income option which guarantees a base income for life that can never be outlived. With the increase of life expectancy there is a danger of depleting capital during advanced years. However, the group annuity assures, at least, a base or fixed income which cannot be outlived. Of equal importance, is the fact that settlement may be arranged under the group annuity to guarantee at least a return of the member's investment to his beneficiary if he elects a life income and dies shortly after retirement.

Mutual Fund

The no load open end mutual fund, consisting primarily of common stocks, is managed by Stein Roe & Farnham of Chicago, which has been serving as investment adviser to pension and profit sharing trusts, trustees, individuals, and other investors since 1932.

The Stein Roe & Farnham Stock Fund is quoted daily in most major newspapers and the *Wall Street Journal*. The fund has no sales commissions. The investment adviser receives a quarterly management fee of $\frac{1}{8}$ of 1 per cent of the average net asset value of the fund. Management fees are common to all mutual funds and are distinct from sales loads.

Members wishing additional information on the Society's sponsored program may write to the Illinois State Medical Society, Division of Economics & Insurance, 360 N. Michigan Ave., Chicago.

Group Disability Program

The Illinois State Medical Society has officially approved a group disability program which is available to all eligible members of the ISMS up to age 70 who are regularly attending all of the usual duties of their occupation. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

Provision has been made for an adjudication committee to advise the carrier on claims and other administrative problems. The adjudication committee will review the medical data and make recommendations regarding coverage which the insurance company might otherwise reject.

The program is explained in detail in a brochure which is available from the Society or by writing directly to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie.

Group Major Medical Expense Plan

The \$15,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has a 20% co-insurance feature and a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to \$30 a day and up to \$45 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to \$2,000 for dependents. It will also cover a congenital anomaly from the first day of birth after the effective date of the contract up to \$2,000.

New members joining the Society will be allowed to enroll without evidence of insurability or a health statement under age 40 within 12 months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N. J., and is administered by Parker, Aleshire & Co., Chicago. Additional information may be obtained from the Illinois State Medical Society, Division of Economics and Insurance.

The Relative Value Study

The Relative Value Study, undertaken by the Relative Value Committee, was completed, printed, submitted to and approved by the ISMS House of Delegates in 1964. Copies of the study are available from the Society. The study is a compilation of unit values referred to as relative value indexes, and derived from average fees customarily charged by Illinois physicians for services rendered to patients.

The primary purpose of the Relative Value Study is to provide individual physicians with a reliable factual guide for evaluating their own services. It may also be utilized by the profession as a whole in developing and negotiating payment schedules designed to fit a wide range of circumstances. In this respect, the advantages accruing to the profession are numerous since many existing payment schedules are based on subjective opinion with few or no statistical guidelines.

The 1961 House of Delegates authorized the study and approved it with modifications at the 1963 annual meeting. The statistical techniques employed in this study, the data resulting therefrom, the wealth of information contained in the study itself and its adaptability make the study superior to similar studies previously undertaken.

Medical Career Recruitment Programs

As man has advanced his life expectancy, it follows that many additional young men and women are and will be needed as members of the health team. Youth must be counseled early in their academic years in order to receive the proper educational background for a doctorate of medicine or allied health field degree.

The Woman's Auxiliary of the ISMS has been the spearhead force in Illinois to interest and recruit the youth of the state in medical careers. Members are asked to aid this effort by investigating the possibility of conducting or participating in career days in their home communities.

A pamphlet entitled "The Opportunities and Rewards of Medicine Can Be Yours" and a "Career Information Form" are available from the society.

Assistance to the Medically Indigent Aged Through Kerr-Mills

Assistance to the Medically Indigent Aged (AMIA) is a program enacted in Illinois to help elderly citizens on limited income and resources pay their medical and hospital bills and enjoy their golden years in good health. Kerr-Mills is paid for by state and federal funds and administered on the local level to assure health care when serious illness strikes and finances of the aged are low.

It provides hospitalization with all drugs, laboratory tests, special treatments, nursing and other essential services for the duration of the hospital stay; follow-up care after release from the hospital, with physician's visits and prescribed drugs for 30 days; and convalescent or rehabilitation care in a nursing home after release from the hospital, for 90 days, together with the services of a physician and necessary drugs.

Applicants for medical assistance under Kerr-Mills must be 65 years of age or older and must be residents of Illinois, having established a permanent home in the state at the time of application. There is no durational residence requirement and temporary absence does not affect the resident status. The

annual income of a single person with no dependents should not exceed \$1,800; a couple is allowed \$2,400 plus \$600 for each additional dependent. Property and other resources for a single person should not exceed \$1,800; a married couple is allowed \$2,400 plus \$400 for each dependent. Property and other resources mean "liquid or marketable assets," exclusive of the applicant's homestead and contiguous real estate; clothing, household effects, and automobiles; life insurance having a cash value of \$1,000 or less; tangible personal property used in earning income having a fair market value of \$1,000 or less.

If the applicant is able to meet these requirements, he is probably eligible for Kerr-Mills assistance. If his income or resources exceed these amounts, he may still be eligible after first applying the excess toward the medical costs. The amount of medical expenses for which the applicant is responsible is based on income and the value of resources.

Family responsibility (sons and daughters) is part of the Illinois law; the County Department of Public Aid determines if the responsible relatives are financially able to meet the cost of the allowable medical services. The amount of aid will vary according to their financial situation.

Application should be made prior to or during the hospital stay. Application should be made to the County Department of Public Aid in county where the patient resides.

Brochures on Kerr-Mills, entitled "Need Help When You're Ill? Here's How Kerr-Mills Pays the Bill," are available in any quantity from The Illinois State Medical Society.

Comb-1 Insurance Form

Because of the variety of data required for health insurance claims, the Comb-1 Form was developed jointly by the American Medical Association and the Health Insurance Council to simplify and reduce the number of attending physicians forms equally acceptable to the health insurance industry and the medical profession.

Information requested by many diverse forms from a large number of insurance companies was first classified and minimum needs for claim purposes were determined. Then appropriate and clearly worded questions were developed and arranged in a standard sequence, to facilitate completion. Out of this came two basic forms, one for group health insurance and one for individual health insurance, and four abbreviated forms. A further simplification involved devising an all-purpose form which is a combination of the group and individual forms—the Comb-1 Simplified Health Insurance Claim Form.

These forms are available to physicians from the Illinois State Medical Society and should be substituted for any non-standardized forms received. Each physician has been asked to voluntarily adopt the following procedure:

- 1) When a physician receives a form from an insurance company bearing the HIC symbol it should be completed and returned to the company.
- 2) When a physician receives a form *not* identified by the HIC symbol, the standardized form should be filled out and clipped to the unacceptable form with both forms returned to the insurance company.
- 3) If the insurance company insists upon having its own form completed, the doctor should feel justified in making a reasonable charge for the added work involved in handling the non-standardized form.

The attempt to standardize these forms is an aid in cutting back on the ever-increasing load of paper work involved in medical practice. Forms are available without charge from the ISMS Division of Economics and Insurance while the supply lasts.

The Senior Citizen Blue Shield Plan

The Senior Citizen Blue Shield Plan, as approved by the Illinois State Medical Society, was designed specifically to provide medical-surgical coverage for the aged at a reasonable cost.

The plan includes a schedule of allowances based on the professional service index covering services to all persons over 65 years of age. Examples of these maximum allowances follow herewith. These allowances would be accepted by a physician as payment in full only for individuals with incomes of less than \$2,500 and for families where the combined income of husband and wife does not exceed \$4,000. Those with greater incomes would be expected to pay the physician's usual fees with the allowance of this senior citizen plan applied against such fees.

Thus this program retains free choice of physician and the right of the physician to set his own fees for patients who are able to pay.

For the medically indigent the Kerr-Mills type of legislation still would be available to provide financial assistance to people over 65 who cannot provide medical coverage for themselves.

EXAMPLES OF MAXIMUM ALLOWANCES

SURGICAL SERVICE

ABDOMEN

Appendectomy	\$105.00
Cholecystectomy	157.00
Subtotal Gastrectomy	206.00

BREAST

Mastectomy, simple, unilateral.....	\$ 84.00
Mastectomy, radical, unilateral.....	171.00

CHEST

Thoracotomy, exploratory	\$128.00
Pneumectomy	258.00

FRACTURES

Ankle, bimalleolar including Potts'.....	\$ 76.00
Phalanx, one finger or thumb, simple....	15.00

DISLOCATIONS

Hip (Femur)	\$ 87.00
Knee (Tibia), simple.....	50.00
Shoulder (Humerus), simple.....	35.00

CARDIOVASCULAR

Ligation and division of saphenous vein with or without retrograde injection, or distal interruptions, unilateral.....	\$ 52.00
With Stripping (Multiple distal interruptions), unilateral	84.00

GENITO-URINARY TRACT

Nephrectomy	\$189.00
Prostatectomy, transurethral resection...	177.00

HERNIA

Hernioplasty, unilateral	\$ 99.00
Recurrent	113.00

INFECTIONS

Drainage of furuncle.....	\$ 9.00
Drainage of carbuncle.....	12.00

GYNECOLOGY

Panhysterectomy; total hysterectomy (corpus and cervix).....	\$168.00
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PARACENTESIS, TAPPING

Abdominal paracentesis	\$ 9.00
Thoracentesis	9.00

RECTUM

Complete proctectomy, combined abdominoperineal, one or two stages...	\$258.00
Hemorrhoidectomy, internal	73.00

GENERAL MEDICAL CARE

First daily visit.....	\$ 9.75
Second daily visit.....	6.50
Third through seventieth daily visit....	3.25

DIAGNOSTIC X-RAY SERVICE

Ankle	\$ 9.00
Elbow	9.00
Gallbladder (dye)	18.00
Skull, multiple views.....	23.00
Chest	9.00

RADIATION THERAPY

Superficial (soft X-ray), per treatment	\$ 9.00
Deep X-ray (orthovoltage), per treatment	9.00
Megavoltage X-ray (cobalt, Betatron), per treatment	14.00
Radium plaque or mold, per treatment...	14.00
Radium implantation, per treatment....	68.00

CLINICAL AND SURGICAL PATHOLOGY

Blood count, complete.....	\$ 4.00
Spinal fluid, routine chemical and microscopic	8.00
Sputum, smear, direct.....	3.00
Tissue sections	12.00
Urinalysis, complete routine.....	3.00

ANESTHESIA

Appendectomy	\$ 21.00
Cholecystectomy	32.00
Gastrectomy, subtotal	41.00
Hysterectomy	35.00
Prostatectomy	35.00

Physicians Placement & Student Loan Fund Program

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physicians Placement Service. Second is the Illinois Student Medical Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

Physicians Placement Service

The Physicians Placement Service is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a resident physician.

More than 400 medical doctors have been placed through this program since its inception shortly after World War II.

The Physicians Placement Service maintains an up-to-date listing of some 150 "open" areas needing general practitioners. It maintains a similar listing of areas in need of specialists in a given field.

This service accepts requests from both physicians and communities for satisfactory placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association, the Illinois State Health Department and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will contact the service.

Another important function of the Physicians Placement Service is to assist small communities in developing programs to attract physicians.

The Physicians Placement Service sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics. The physician is also sent bulletins with information on new locations as they develop.

The Physicians Placement Service offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society. There is no charge either to the physician or to the community seeking the services of this program.

Inquiries may be addressed to the Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Avenue, Chicago, Illinois, 60601.

Illinois Student Medical Loan Fund Program

The Illinois Student Medical Loan Fund Program is designed to help those who have got what it takes

to become a physician but lack the money or a recommendation for medical school. Since its inception in 1948, the program has helped over 125 qualified applicants to hurdle financial or borderline academic barriers to a medical education.

Loans to students in need are provided by joint contributions from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans of \$625 per semester—up to a total of \$5,000 over a four-year period. A two per cent interest rate is charged semi-annually from the time the loan is received. The borrower must also insure himself for the entire amount of the loan and pay premiums on the policy. However, he has seven years—time to complete his education, internship and two years of practice—before the first principal payment is due.

The program also offers assistance to those who may not have financial difficulties but can't get into a "Class A" medical school because their college grades are marginal. The board representing the sponsoring organizations of the program can recommend 10 candidates annually to the University of Illinois College of Medicine in Chicago. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Student Medical Loan Fund Program, the applicant must agree to practice medicine in an Illinois town—generally of approximately 5,000 population—for five years. The applicant may select a town from an up-to-date list of communities which have demonstrated need and ability to support a physician, but choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the smaller rural communities in Illinois.

To be considered for assistance from the Student Medical Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a male pre-medical student of at least three years college standing . . . an Illinois resident outside of Cook County . . . and that he take a medical college admissions test for review by the program's board.

The board of the Student Medical Loan Fund Program conducts its annual interview about Feb. 1 for those students who wish to enter medical school the following September. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, secretary, Joint Student Medical Loan Fund Board, Illinois Agricultural Association, 1701 Towanda Ave., P.O. Box 901, Bloomington.

Scientific Speakers Bureau

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies

in their efforts to keep members abreast of medical advances. Sponsored by the ISMS Committee on Continuing Education, the bureau helps local groups arrange and conduct postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, helping them with travel arrangements, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharp & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

2) Eight weeks advance notice is required for postgraduate meetings. Requests for such meetings, which usually are scheduled for an entire afternoon, should be sent to the chairman of the Committee on Continuing Education, Illinois State Medical Society, 360 N. Michigan Ave., Chicago.

3) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

4) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

5) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

Doctor's Responsibility to the Press

Physicians and the press are partners in providing a link of communication between the medical profession and the public. But, the press cannot carry out its traditional responsibility in informing the public in the area of medical and patient news without the cooperation of the medical society and individual doctors. The inevitable penalty of silence by the doctors is public ignorance, misunderstanding and fear. In a democracy, public ignorance, misunderstanding and fear can be dangerous to professional freedom.

The following outline—based on a press code adopted by the Macon County Medical Society—is suggested as a pilot guide for individual physicians and county societies in Illinois.

Availability

1) The officers, committee chairmen or designated spokesmen of county medical societies shall be available at all times to mass media personnel to provide authentic information on medical subjects.

2) A list of current spokesmen shall be supplied by county societies to the executives of every newspaper, radio and television station in the country.

3) These spokesmen may be quoted by name. They should not be considered by their colleagues as self-seeking, since authoritative attribution is done in the best interests of the public and the profession. (In addition, physicians are private citizens and as such are the subjects of news stories in their social and civic activities just like any other citizen.)

Physician News

Physicians, as scientists, are encouraged to give newspaper interviews and appear on radio and television programs on medical subjects. Physicians may report on new or unusual diseases or treatments within an ethical framework. In these instances, they should, whenever possible, notify their county society publicity chairman or the Illinois State Medical Society.

Physicians may be asked to comment as individuals on politically controversial subjects (such as socialized medicine). In this event, the physician should clearly indicate that he is expressing his personal viewpoint which should not be construed as a statement of medical society policy.

A medical society officer, however, should remember that any comment he makes—whether or not intended as personal viewpoint—is generally accepted as official policy.

Patient News

As the patient's personal physician, the doctor has an obligation to respect confidences that come to him in the performance of his duty and may not release news except with the patient's consent or those authorized to speak for him. When the press learns of the illness of private patients from other sources, the physician may cooperate with the press in answering any inquiries in the interest of accuracy and to avoid embarrassment.

When news of patients is of such a nature that it automatically falls in the public domain (see next section) physicians should feel free to release information within the framework of this code.

Patient information may be given where the nature of injuries, illness or treatment is of special interest. The report of such information shall be more in the nature of scientific information, rather than an exposé of an individual affliction.

Public Domain

News of public domain includes births, deaths, accidents, police cases, and persons prominent in the public eye. The following information may be made available:

1) Personal Information including:

Patient's name, address, age, sex, race, marital status, employer, occupation, name of newborn's parents, name of next-of-kin, and name of undertaker.

2) Nature of Accident

- a) Only general information regarding injuries should be released.
- b) It may be stated that there are internal injuries.
- c) If the patient is unconscious when brought to the hospital, a statement to that effect may be made.
- d) A knife or a bullet wound may be identified as such, but no statement should be made on the circumstances in which the wound was inflicted.
- e) A statement may be made that the patient received burns and the part of the body affected may be indicated.
- f) No statement should be made that the patient has been poisoned—except by accident—nor should the poisonous substance be identified in describing the patient's injury.
- g) No statement should be made that there was suicide or attempted suicide.
- h) No statement should be made that intoxication or drug addiction was involved in the patient's condition.
- i) No statement shall be made that moral turpitude was involved in a patient's condition.

3) Diagnosis and Prognosis

- a) Inasmuch as a diagnosis may be made only by

a physician and may depend on X-ray and laboratory studies, no diagnosis should be made except by the attending physician.

- b) For the above reason, prognosis should be given only by the attending physician or at his direction.

4) Patient's Condition

A statement may be made as to the general condition of the patient with the following classifications: a) Minor Injuries, b) Good, c) Fair, d) Serious, e) Critical.

Photographs

Written Consent or witnessed verbal consent of patients and the attending physician are necessary before pictures can be taken in the hospital. If a patient is a minor, the permission of the parents and the attending physician will be required.

Deceased or Unconscious Patients may not be photographed, except in police cases.

Patients With Severe Burns or Facial Injuries, generally, will not be photographed even though consent is obtained. Sound judgment must govern exceptions.

Photographs have strong reader appeal and should be used whenever they can be used in good taste to heighten the effect of stories.

WOMAN'S AUXILIARY TO THE ILLINOIS STATE MEDICAL SOCIETY

"Nearer and closer to our hearts be the Christmas spirit, which is the spirit of active usefulness, perseverance, cheerful discharge of duty, kindness, and forbearance!"

—Charles Dickens

The above quote may make you think of "Christmas in July," but the idea is certainly an excellent one. Won't you take time to have this spirit prevail throughout the state all year? The Woman's Auxiliary to the Illinois State Medical Society offers ample opportunities for all physicians' wives to give of themselves. It is a privilege to be a member of a medical auxiliary and participate in its varied programs. The only requirement is that the woman be the wife or widow of a physician who is a member in good standing of his county medical society.

Our goal this year is to increase our membership. It is the national auxiliary's aim to have team memberships with both the physician and his wife members of an auxiliary or society, joining when his dues are paid.

Legislation will be stressed again this year; the time is NOW to write your congressmen in regard to a "better care than medicare."

Take an active part in community affairs: health drives, fairs, church groups, P.T.A., etc., always striving to create a better image of the doctor in the community.

In Illinois we have a Benevolence Committee. It

is our way of helping those among us who need care.

Other committees are International Health Activities (last year medical supplies, books, and journals were sent to 15 countries as a result of the diligent work of this committee), Mental Health, Rural Health, AMA-ERF, Allied Health Careers (it is hoped that the scholarships and loans of about \$8,000.00 provided last year will be duplicated), and Disaster Preparedness. Always remember that whatever we undertake is done so with the approval and supervision of the advisory committee.

It is the duty of each member to talk auxiliary to her friends. Invite them to meetings; if programs are made stimulating and informative they will remain interested. The auxiliary provides the implements to be a useful and active individual. It is up to you to take advantage of them to keep the Christmas spirit in your heart throughout the year.

MRS. JOHN W. KOENIG
President

1965-1966

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 CORR. SECY., Mrs. Sherman C. Arnold, 10856 S. Ave. "L", Chicago 60617
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 Mrs. Richard Icenogle, Roseville
 INTERNATIONAL HEALTH ACTIVITIES, Mrs. Wendell Roller, 309 S. Main St., Monmouth
 LEGISLATION, Mrs. John Van Prohaska, 5830 Stony Island Ave., Chicago 60637
 MEMBERSHIP, Mrs. Newton DuPuy, 1842 Grove Ave., Quincy
 MENTAL HEALTH, Mrs. August Martinucci, 1210 Mason Ave., Joliet

PARLIAMENTARIAN, Mrs. Percy M. Clark, 5722 Franklin Ave., LaGrange
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 SAFETY, Mrs. Joseph Shanks, 3121 Sheridan Rd., Chicago 60657
 W.A.S.A.M.A., Mrs. Lewis A. Hare, 10811 S. Fairfield Ave., Chicago 60643
 MEMBERS-AT-LARGE, Mrs. Wilson West, 14 Oakwood Dr., Belleville
 *HOSTESS, Mrs. Richard Icenogle, Roseville

DISTRICT COUNCILORS

1965-1966

1. Boone, DeKalb, Jo Daviess, Kane, Lake Stephenson, Winnebago, Mrs. Paul F. Wilkinson, 3204 North View Rd., Rockford (Winnebago)
2. Bureau, LaSalle, Lee, Livingston, Whiteside, Mrs. Donald Morehead, 1447 Birchlawn, Ottawa (LaSalle)
3. Cook, Mrs. Mitchell Spellberg, 7408 S. Clyde, Chicago 60649
 Mrs. Silvio Del Chicca, 2600 N. Lakeview, Chicago 60614
 Mrs. Richard E. Westland, 5114 Farwell, Skokie
4. Henry, Knox, Mercer, Peoria, Rock Island, Warren, Mrs. Paul Palmer, 1511 Bigelow Peoria (Peoria)
5. Logan, McLean, Sangamon, Tazewell, Mrs. Lloyd Teter, 712 S. 6th St., Pekin (Tazewell)
6. Adams, Madison, Mrs. Maurice Woll, 164 Norwood Pl., East Alton (Madison)
7. Christian, Effingham, Macon, Marion-Clinton, Mrs. Glen Marshall, 802 E. Jefferson, Effingham (Effingham)
8. Champaign, Coles-Cumberland, Crawford, Vermilion, Mrs. Randolph Olmstead, 702 Locust Ln., Robinson (Crawford)
9. Jefferson-Hamilton, Saline-Pope-Hardin, Mrs. C. K. Wells, 701 Pavey, Mt. Vernon (Jefferson-Hamilton)
10. St. Clair, St. Clair-Belleville Branch, Mrs. Howard Lange, 9 Berrywood Dr., Belleville (St. Clair-Belleville Branch)
11. DuPage, Kankakee, Will-Grundy, Mrs. Richard J. Graff, 100 Barnard Rd., Manteno (Kankakee)

LEGISLATIVE AND MEDICAL SERVICE ORGANIZATIONS



WHILE THE ILLINOIS STATE MEDICAL SOCIETY itself is strictly non-partisan in politics, it urges all of its members to take an active interest in political affairs. The organization often takes a stand on legislative questions, but never supports candidates, although it encourages its members to do so.

Officers of ISMS believe that it is the duty of physicians to become politically informed and to participate in public affairs. The following section is a directory of state government officials, agencies and functions as well as a reference to medically-related private or independent organizations.

It should be pointed out that the listing was up-to-date at the time of publication, but that the nature of the directory is such that its contents are constantly changing.

It should be particularly noted that failure of the state to reapportion its districts in accordance with the 1960 census caused members of the House of Representatives in the 74th General Assembly to be elected from the state at-large, rather than from individual districts and that the 1965 General Assembly also failed to re-district the state.

At the time of publication it was unknown how the 75th General Assembly would be elected. It was announced that reapportionment of State Senatorial districts, as well as U.S. Congressional Districts, would be under the jurisdiction of the Illinois Supreme Court and that a bipartisan commission would be appointed by the Governor to reapportion legislative districts for the state's House of Representatives in accordance with existing laws.

Congressional Assignments to Committees

Senator Everett M. Dirksen (R), Pekin

Minority Leader
Term Expires 1969
Committee on Finance
Committee on the Judiciary

Cook County

DISTRICT

- 1 Rep. William L. Dawson (D), Chicago
Committee on District of Columbia
Committee on Government Operations,
Chairman
- 2 Rep. Barratt O'Hara (D), Chicago
Committee on Foreign Affairs
- 3 Rep. William T. Murphy (D), Chicago
Committee on Foreign Affairs
- 4 Rep. Edward J. Derwinski (R), South Holland
Committee on Foreign Affairs
Committee on Post Office & Civil Service
- 5 Rep. John C. Kluczynski (D), Chicago
Committee on Public Works
Select Committee on Small Business
- 6 Rep. Daniel J. Ronan (D), Chicago
Committee on Interstate & Foreign Commerce
- 7 Rep. Frank Annunzio (D), Chicago
Committee on Banking & Currency
- 8 Rep. Daniel D. Rostenkowski (D), Chicago
Committee on Ways & Means
- 9 Rep. Sidney R. Yates (D), Chicago
Committee on Appropriations
- 10 Rep. Harold R. Collier (R), Berwyn
Committee on Ways & Means
- 11 Rep. Roman C. Pucinski (D), Chicago
Committee on Education & Labor
- 13 Rep. Donald Rumsfeld (R), Glenview
Committee on Science & Astronautics
Committee on Government Operations

Senator Paul H. Douglas (D), Chicago

Term Expires 1967
Committee on Banking & Currency
Committee on Finance

Downstate

- 12 Rep. Robert McClory (R), Waukegan
Committee on Judiciary
- 14 Rep. John N. Erlenborn (R), Elmhurst
Committee on House Administration
Committee on Government Operations
- 15 Rep. Charlotte T. Reid (R), Aurora
Committee on Interior & Insular Affairs
Committee on Public Works
- 16 Rep. John B. Anderson (R), Rockford
Committee on Rules
Joint Committee on Atomic Energy
Select Committee on Government Research
- 17 Rep. Leslie C. Arends (R), Melvin
Committee on Armed Services
- 18 Rep. Robert H. Michel (R), Peoria
Committee on Appropriations
- 19 Rep. Darwin G. Schisler (D), London Mills
Committee on Science & Astronautics
- 20 Rep. Paul Findley (R), Pittsfield
Committee on Agriculture
Committee on Education & Labor
- 21 Rep. Kenneth J. Gray (D), Frankfort
Committee on Public Works
Committee on House Administration
- 22 Rep. William L. Springer (R), Champaign
Committee on District of Columbia
Committee on Interstate & Foreign Commerce
- 23 Rep. George E. Shipley (D), Olney
Committee on Appropriations
- 24 Rep. Melvin Price (D), East St. Louis
Committee on Armed Services
Joint Committee on Atomic Energy
Select Committee on Government Research

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive, and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 58 senatorial districts and 59 representative districts. Each senate district elects one senator; each representative district elects three representatives. Thus, the Senate has 58 members and the House 177. The senators are elected for four-year terms, and the representatives serve two-year terms. Senators in the districts having even numbers are elected in Presidential election years;

those in districts with odd numbers are chosen at elections in the intervening even-numbered years.*

The General Assembly normally meets in the first six months of each odd-numbered year, although may be called into special session by the Governor. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, propose and submit amendments to the State Constitution, and to act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the Lieutenant Governor. To facilitate the handling

of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

*In the event that reapportionment of the state's senatorial and representative districts is not accomplished by November of 1966, the entire House and Senate will be elected on an at-large basis.

**74TH ILLINOIS
GENERAL ASSEMBLY**

STATE SENATORS
(Term four years)

(Senators in even numbered districts were elected Nov. 3, 1964, those in odd numbered districts were elected Nov. 6, 1962. Republicans, 33; Democrats, 24.)

District	Name, Politics and Address
4	Arrington, W. Russell (R), 929 Edgemere Ct.
36	Awerkamp, Thomas J. (D), 2505 Cherry St., Quincy
48	Benefiel, Philip B. (D), 333 Lincoln Dr., Lawrenceville
1	Bidwill, Arthur J. (R), 1403 Bonnie Brae, River Forest
46	Broyles, Paul W. (R), P.O. Box 933, Mt. Vernon
53	Carpentier, Donald D. (R), 2208 37th St., Moline
27	Cherry, Robert E. (D), 4300 Marine Dr., Chicago
35	Collins, Dennis J. (R), 545 Northern Lane, DeKalb
52	Coulson, Robert (R), 1031 Pacific Ave., Waukegan
15	Cronin, A. L. (D), 111 W. Washington St., Room 1449
26	Davis, David (R), 304 Unity Bldg., Bloomington
25	De La Cour, Joseph L. (D), 185 E. Chestnut St., Chicago
7	DeTolve, Anthony J. (D), 1037 W. Vernon Park Pl., Chicago
49	Dixon, Alan J. (D), 25 W. Main, Belleville
42	Donnewald, James H. (D), 625 N. Clinton, Breese
13	Dougherty, Daniel (D), 1957 E. 93rd St., Chicago
45	Drach, George E. (R), 1524 Noble Ave., Springfield
41	Fawell, Harris W. (R), 444 S. Sleight, Naperville
9	Finley, Morgan M. (D), 3550 S. Lowe Ave., Chicago
44	Gilbert, John G. (R), 513 W. Walnut St., Carbondale
8	Gottschalk, Arthur R. (R), 320 Marquette St., Park Forest

3	Graham, John A. (R), 715 S. Cook, Barrington
34*	Graham, Paul (R), 116 Wabash Ave., Mattoon
50	Grindle, William L. (D), 216 Circle Dr., Herrin
30	Groen, Egbert B. (R), 34 S. Fourth St., Pekin
16	Harris, William C. (R), 706 S. Walnut St., Pontiac
39	Hart, Fred J. (R), 114 N. Monroe St., Streator
19	Hatch, Robert F. (R), 10615 S. Hale Ave., Chicago
29	Hoffelder, Walter P. (R), 5730 N. Menard Ave., Chicago
51	Kerr, Gordon E. (R), Route No. 1, Brookport
5	Kinnally, Nathan J. (D), 7234 S. Paxton Ave., Chicago
23	Kocarek, Frank J. (D), 1718 S. Loomis St., Chicago
33	Kusibab, Thad L. (D), 2043 W. Augusta Blvd., Chicago
12	Lanigan, John J. (R), 6424 S. Karlov Ave., Chicago
57	Larson, Richard R. (R), 400 Bondi Bldg., Galesburg
32	Latherow, Clifford B. (R), R.R. 3, Carthage
56	Laughlin, Everett E. (R), 300 State Bank Bldg., Freeport
10	Lyons, Thomas G. (D), 6457 N. Hiawatha, Chicago
38	Lyons, William D. (D), 501 E. Elm St., Gillespie
28	McCarthy, Robert W. (D), Arcade Bldg., Lincoln
21	McGlooin, Thomas A. (D), 134 N. LaSalle St., Chicago
20	Martin, Samuel L. (R), P.O. Box 146, Watseka
22	Merritt, Tom (R), 818 E. Maple St., Hoopston
58	Mitchler, Robert W. (R), Hill Spring Oaks, R.R. 1, Oswego
31	Neistein, Bernard S. (D), 4123 W. Harrison St., Chicago
6	Ozinga, Frank M. (R), 3101 W. 95th St., Evergreen Park
24	Peters, Everett R. (R), 501 S. Fifth St., St. Joseph
37	Peterson, Joseph R. (R), 1309 S. Main St., Princeton
54	Rosander, Bertil T. (R), 615 Oak Knolls Ave., N., Rockford
47	Simon, Paul (D), 306 E. Market, Troy
11	Smith, Fred J. (D), 4949 S. Parkway, Chicago
18	Sours, Hudson R. (R), 2623 W. Moss Ave., Peoria
2	Sprague, Arthur W. (R), 345 S. Spring Ave., LaGrange
17	Swanson, Arthur R. (R), 12556 S. Harvard Ave., Chicago
14	Vacant
40	Traynor, Stuart J. (D), 302 E. Market, Taylorville
43	Welch, Robert A. (D), P.O. Box 40, Canton
55	Ziegler, Paul A. (D), 700 N. Second St., Carmi

*Deceased

REPRESENTATIVES

(Term two years)

(Elected At Large Nov. 3, 1964,
Republicans 59, Democrats 116)

County	Name, Politics and Address		
Macon	Alsup, John W. (D), 1712 N. Church St., Decatur	Perry	Cunningham, William J. (R), 804 W. Belle Ave., Pinckneyville
Franklin	Baker, Bert (D), 205 W. Fifth St., Benton	Champaign	Dale, Edwin E. (R), 307 Elmwood Rd., Champaign
Bureau	Barry, Tobias (D), 304 Central Ave., Ladd	Cook	Daley, John M. (D), 8125 S. Talman Ave., Chicago
Lake	Berry, Francis J. (R), 201 N. Third, Libertyville	Cook	Davis, Cornael A. (D), 3223 S. Calumet Ave., Chicago
Cook	Blair, W. Robert (R), 124 Shabbona Dr., Park Forest	Cook	Dawson, Frances L. (Mrs.) (R), 2609 Lincoln St., Evanston
Cook	Blaser, William L. (R), 110 LaRue, Park Forest	Cook	DeMichaels, LaSalle J. (D), 2851 W. Fletcher St., Chicago
Cook	Boswell, Paul P. (R), 5211 S. Greenwood Ave., Chicago	Cook	DiPrima, Lawrence (D), 543 N. St. Louis Ave., Chicago
DuPage	Bowers, Jack (R), 806 Maple, Downers Grove	Cook	Downes, John P. (D), 8831 S. Paulina St., Chicago
Cook	Broucek, Frank J. (D), 2118 East Ave., Berwyn	Cook	Downey, Frank X. (D), 5085 Lamb Dr., Oak Lawn
Cook	Burditt, George M. (R), 540 S. Park Rd., LaGrange	Cook	Eisenhower, Earl D. (R), 424 Homestead, LaGrange
Iroquois	Callahan, Joseph (D), R.R. 3, Milford	Cook	Elward, Paul F. (D), 1532 W. Chase Ave., Chicago
Winnebago	Canfield, Robert R. (R), R.R. No. 4, Rockford	Cook	Enzzino, Andrew A. (D), 905 S. Western Ave., Chicago
Peoria	Carrigan, James D. (D), 819 Hamilton Blvd., Peoria	Cook	Fanta, Joseph F. (D), 2156 W. Waveland Ave., Chicago
Cook	Carroll, John W. (R), 29 Fairview, Park Ridge	Cook	Fary, John G. (D), 3600 S. Damen Ave., Chicago
Cook	Carter, James Y. (D), 601 E. 32nd St., Chicago	LaSalle	Fennessey, Joseph (D), R.R. No. 2, Ottawa
Peoria	Cassidy, John E., Jr. (D), 6526 St. Mary Rd., Peoria	Franklin	*Fitzgerrell, Wayne (R), 108 Callie St., Sesser
Cook	Chapman, Eugenia S. (Mrs.) (D), 903 N. Kaspar Ave., Arlington Hts.	Sangamon	Frey, William J. (D), R.R. No. 2, Pleasant Plains
Union	Choate, Clyde L. (D), Box 87, Anna	Cook	Garnisa, Benedict (D), 3303 W. Crystal St., Chicago
Champaign	Clabaugh, Charles W. (R), 901 W. Daniel St., Champaign	Cook	Geisler, Herbert F. (R), 3743 W. Fullerton Ave., Chicago
Cook	Clarke, Terrel E. (R), 4070 Central Ave., Western Springs	McHenry	Giblin, William A. (D), R.R. No. 2, Marengo
Cook	Collins, Otis G. (D), 3906 W. 15th St., Chicago	Winnebago	Giorgi, E. J. (D), 1024 Blake St., Rockford
Coles	Connelly, Joseph T. (D), 2009 Cleveland St., Charleston	Cook	Goldstiek, Phillip C. (D), 8535 N. Christiana, Skokie
Lake	Connolly, John H. (R), 221 Washington St., Waukegan	Adams	Grow, Dorah (Mrs.) (D), 1650 1/2 Vermont St., Quincy
St. Clair	Costello, Dan E. (D), 1528 N. 43rd St., E. St. Louis	Cook	Hachmeister, Albert W. (R), 423 W. Barry Ave., Chicago
Cook	Course, Kenneth W. (D), 3413 W. Armitage Ave., Chicago	McHenry	Hanahan, Thomas J., Jr. (D), 2012 Grandview, McHenry
Vermilion	Craig, Robert (D), Indianola	Cook	Hannigan, Michael E. (D), 6646 S. Honor St., Chicago
		Madison	Harris, Lloyd (D), 3233 Aubrey Ave., Granite City
		Lake	Hartnett, William E. (D), R.R. No. 2, Box 548, Lake Villa
		Kane	Hill, John Jerome (D), 741 Sheridan St., Aurora
		*Deceased	

Randolph	Holloway, James D. (D), 211 W. Broadway, Sparta	Cook	McCormick, Hope (Mrs.) (R), 1939 N. State Parkway, Chicago
Sangamon	Horsley, G. William (R), 316 E. Adams St., Springfield	Woodford	McCully, Dean (R), 430 E. Fourth St., Minonk
Cook	Houlihan, John J. (D), 213 Towanda, Park Forest	Cook	McDermott, Michael H. (D), 6706 S. Wood St., Chicago
Peoria	Hurst, Ronald Alan (R), 4708 N. Clarewood Dr., Peoria	Cook	McDevitt, Bernard (R), 21 N. Mason Ave., Chicago
Rock Island	Jacobs, Oral (D), 303 19th St., East Moline	Cook	McLendon, James A. (D), 100 N. LaSalle St., Chicago
Edgar	Jenison, Edward H. (R), The Beacon-News, 218 N. Main, Paris	Cook	McNairy, Melvin (D), 1466 W. 113th Pl., Chicago
Cook	Johuston, Alan R. (R), 206 Cumberland Ave., Kenilworth	Cook	McNichols, John J. (D), 1954 Hull Ave., Westchester
Sangamon	Jones, J. David (R), 6 Walnut Ct., Springfield	Cook	McPartlin, Robert F. (D), 5100 W. Adams St., Chicago
Clay	Jones, Leslie N. (R), R.R. No. 2, P.O. Box 331, Flora	Stephenson	Mahoney, Francis X. (D), 707 E. Garden St., Freeport
Cook	Katz, Harold A. (D), 1180 Terrace Ct., Glencoe	Cook	Majewski, Chester P. (D), 3906 N. Oketo Ave., Chicago
Cook	Kennedy, John A. (D), 5 Woodley Rd., Winnetka	Cook	Mann, Robert E. (D), 5539 S. Harper Ave., Chicago
Madison	Kennedy, Leland J. (D), 926 Washington Ave., Alton	Cook	Meany, Mary K. (Mrs.) (R), 10331 S. Leavitt St., Chicago
Cook	Kirie, James C. (D), 2826 N. Thatcher, River Grove	Cook	Merlo, John (D), 3018 N. Sheridan Rd., Chicago
Cook	Klein, Carl L. (R), 6428 S. Francisco Ave., Chicago	Cook	Mikva, Abner J. (D), 5545 S. Kenwood Ave., Chicago
Lake	Kleine, John Henry (R), 155 Wooded Lane, Lake Forest	Effingham	Mills, Miles E. (D), 602 S. Second St., Effingham
DuPage	Knuepfer, Jack T. (R), 901 Washington, Elmhurst	Cook	Moore, Don A. (R), 14636 S. Long Ave., Midlothian
Jefferson	Lee, Clyde (D), 818 Pace Ave., P.O. Box A, Mt. Vernon	Richland	Moore, William A. (D), 318 S. Elliott St., Olney
Cook	Lee, Noble W. (R), 5541 S. Woodlawn Ave., Chicago	Cook	Moran, James (D), 1126 Hinman Ave., Evanston
St. Clair	Lehman, Ed (R), 519 N. 38th St., East St. Louis	DuPage	Morgan, Lewis V., Jr. (R), 1144 N. President, Wheaton
Cook	Lenard, Henry M. (D), 8111 S. Colfax Ave., Chicago	Carroll	Morris, John K. (D), R.F.D. No. 1, Chadwick
Cook	Leon, John F. (D), 1811 N. Tripp Ave., Chicago	Henderson	Neff, Clarence E. (R), Stronghurst
Clark	Lewis, John W., Jr. (R), R.R. No. 2, Marshall	St. Clair	Obernuefemann, Leo B. (D), 223 N. Lincoln, O'Fallon
Macon	Lieberman, Marvin S. (D), 2449 W. Forest St., Decatur	Knox	O'Brien, Leo F. (D), Suite 401, Hill Arcade, Galesburg
Will	Loughran, Francis J. (D), 1220 Sterling Ave., Joliet	Madison	O'Neill, Daniel (D), 853 McKinley Blvd., Alton
Cook	Loukas, James P. (D), 2612 W. Faragut Ave., Chicago	Livingston	Oughton, James H., Jr. (R), The Keeley Institute, Dwight
Sangamon	Lucas, Allen T. (D), 2216 Whittier Ave., Springfield	Cook	Papierz, Stanley A. (R), 5460 S. Archer Ave., Chicago
Cook	Lyman, Frank (D), 5000 N. Marine Dr., Chicago	Peoria	Parkhurst, John C. (R), 1607 W. Margaret St., Peoria
Adams	McClain, Elmo (D), 2031 Prairie Ave., Quincy	Cook	Partee, Cecil A. (D), 100 N. LaSalle St., Chicago
Johnson	McCormick, C. L. (R), Vienna	Cook	Pebworth, Marjorie (Mrs.) (R), 14115 S. Wabash, Riverdale

Cook	Peskin, Bernard M. (D), 821 Timber Lane, Northbrook	Cook	Sisler, George F. (R), 38 S. Dearborn St., Chicago
Champaign	Pfeffer, Leo (D), Seymour	Lake	Slater, Howard R. (D), 120 S. Deere Park Dr., Highland Park
Lake	Pierce, Daniel M. (D), 1923 Lake Ave., Highland Park	Saline	Small, Roy Curtis (D), 1121 Roosevelt, Harrisburg
Winnebago	Pierce, William (D), 305 Hunter Ave., Rockford	Cook	Smith, Calvin L. (D), 644 E. 51st St., Chicago
Cook	Pollack, William E. (R), 3829 N. Secley Ave., Chicago	Cook	Smith, Frank J. (D), 4549 S. Emerald Ave., Chicago
Cook	Pusateri, Lawrence X. (R), 905 Winston Dr., Melrose Park	Madison	Smith, Ralph T. (R), 1 Signal Dr., Alton
Rock Island	Railsback, Thomas F. (R), 1834 14th St., Moline	LaSalle	Soderstrom, Carl W. (R), 1001 Riverside Ave., Streator
Cook	Randolph, Paul J. (R), 850 N. De Witt Pl., Chicago	Marion	Stedelin, Harold D. (D), 711 S. Elm St., Centralia
Cass	Ratcliffe, C. R. (D), 1407 Jefferson St., Beardstown	Cook	Stevenson, Adlai E., III (D), 1519 N. Dearborn Parkway, Chicago
Cook	Rayson, Leland (D), 6500 W. 166th St., Tinley Park	LaSalle	Stremblau, Joseph P. (D), R.F.D. No. 2, Box 170, Mendota
DuPage	Redmond, William A. (D), 250 Tioga St., Bensenville	Cook	Svalina, Nick (D), 10723 S. Ave. F., Chicago
McLean	Rhodes, Ben S. (R), 1211 Broadway, Normal	Saline	Tanner, R. B. (D), R.R. No. 1, Harrisburg
Rock Island	Rink, Paul E. (D), 1549 Twenty-Fourth St., Rock Island	Brown	Teehey, Dan (D), 400 W. Cross St., Mount Sterling
Cook	Romano, Sam (D), 736 S. Claremont Ave., Chicago	Cook	Thiem, George (R), 1856 Sherman Ave., Evanston
Cook	Ropa, Matt (D), 1710 W. 21st St., Chicago	Cook	Touhy, John P. (D), 3241 W. Washington Blvd., Chicago
Morgan	Rowe, Harris (R), 110 N. East St., Jacksonville	DuPage	Tumpach, Joseph (D), 4644 Highland, Downers Grove
Cook	Ruddy, Michael A. (R), 1700 W. Garfield Blvd., Chicago	Cook	Vitek, John M. (D), 2953 S. Union Ave., Chicago
Ford	Russell, Joe W. (D), 22 E. Chestnut St., Piper City	Tazewell	Von Boeckman, James (D), 1605 Hamilton St., Pekin
Williamson	Sanders, Omer (D), 901 S. Division St., Carterville	Cook	Walsh, Richard A. (R), 1003 N. Elmwood Ave., Oak Park
Cook	Saperstein, Esther (Mrs.) (D), 1432 W. Rosemont Ave., Chicago	White	Walsh, Robert V. (D), 221 W. North St., Grayville
Cook	Seariano, Anthony (D), 38 W. Rocket Circle, Park Forest	Cook	Walsh, William D. (R), 801 N. Kensington Ave., LaGrange Park
Montgomery	Schaefer, Charles Ed (D), 208 E. Union, Nokomis	Cook	Warman, Edward A. (D), 5250 Jarvis Ave., Skokie
Cook	Schlickman, Eugene F. (R), 6 N. Dunton Ave., Arlington Hts.	Cook	Washington, Harold (D), 366 E. 47th St., Suite 9, Chicago
Cook	Schoeninger, William J. (D), 115 W. North Ave., Chicago	Cook	Welsh, Raymond J., Jr. (D), 911 N. Oak Park Ave., Oak Park
Peoria	Schraeder, Fred J. (D), 205 E. Arcadia, Peoria	Cook	Whalen, Peter J. (D), 8029 S. Vincennes Ave., Chicago
McLean	Scott, J. W. (Bill) (D), 730 Towanda Ave., Bloomington	Cook	Wiktorski, Chester R., Jr. (D), 5300 W. Drummond Pl., Chicago
Kane	Sensor, Edward F. (D), 220 Adams St., Elgin	Calhoun	Wittmond, Carl H. (D), Brussels
Cook	Shaw, Edward J. (D), 2208 W. Walton St., Chicago	Cook	Wolbank, Edward W. (D), 619 N. State St., Chicago
Cook	Simmons, Arthur E. (R), 9421 Le Claire Ave., Skokie	Cook	Wolf, Frank C. (D), 4046 W. 26th St., Chicago

Cook	Wolfe, Bernard B. (D), 120 S. La Salle St., Chicago
Cook	Woodward, Robert M. (R), 1000 N. Lake Shore Dr., Chicago
DuPage	Youle, John Clinton (R), White Thorn Road, Wayne
Cook	Zagone, Nicholas (D), 2265 W. Giddings St., Chicago

Legislative Procedure

Each member of the General Assembly has the right to introduce bills or resolutions. After the introduction of the bill, it is referred to the appropriate committee. If the committee recommends the bill favorably, it is read a first time, usually by title, before the house in which it was introduced. A second reading must be held on a separate legislative day when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading when it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he can either sign it or file it with the Secretary of State without his signature. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Two-thirds of the members elected to the House can override the veto. He can also veto specific items of an appropriations bill.

Appropriation Bills

"Bills making appropriations of money out of the treasury shall specify the objects and purposes for which the same are made, and if the Governor shall not approve any one or more of the items or sections contained in any bill, but shall approve the residue thereof, it shall become a law as to the residue in like manner as if he had signed it. The Governor shall then return the bill with any objections to the items or sections of the same not approved by him to the House in which the bill shall have originated, which House shall enter the objections at large upon its journal and proceed to reconsider so much of said bill as is not approved by the Governor. Any item or section of said bill not approved by the Governor shall be passed by two-thirds of the members elected to each of the two Houses of the General Assembly, it shall become part of said law, notwithstanding the objections of

the Governor. Any bill which shall not be returned by the Governor within ten days, Sundays excepted after it shall have been presented to him, shall become a law in like manner as if he had signed it, unless the General Assembly shall, by their adjournment, prevent its return, in which case it shall be filed with his objections in the office of the Secretary of State within ten days after such adjournment or become a law." (Article V, Section 16, Illinois Constitution)

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, and Secretary of State, Auditor of Public Accounts, Treasurer, and Superintendent of Public Instruction, and Attorney General. All of these officials are elected for four-year terms. The Treasurer is the only elected state official who cannot succeed himself.

STATE OFFICERS

Governor, OTTO KERNER, Dem., Glenview

Lieutenant Governor, SAMUEL H. SHAPIRO, Dem., Kankakee

Secretary of State, PAUL POWELL, Dem., Vienna

Auditor of Public Accounts, MICHAEL J. HOWLETT, Dem., Chicago

State Treasurer, WILLIAM J. SCOTT, Rep., Evanston

Attorney General, WILLIAM G. CLARK, Dem., Chicago

Superintendent of Public Instruction, RAY PAGE, Rep., Springfield

Department of Registration and Education

John C. Watson, Director

John B. Hayes, Superintendent of Registration

Ira T. Dawson, Assistant Director

The department is primarily concerned with the registration and licensing of the 25 different trades and professions. Three scientific surveys—the natural history survey, the water survey and the geologic survey are also under the jurisdiction of R&E, as is the administration of the state museum. The department is the implementing agent of the medical practice act.

Medical Examining Committee

George G. Jackson, M.D., Chicago

William Johnson, M.D., Galesburg

Burtis E. Montgomery, M.D., Harrisburg

L. P. Rehberger, D.C., Highland

Kenneth H. Schnepf, M.D., Springfield

Philip G. Thomsen, M.D., Dolton

Seaver A. Tarulis, D.O., Chicago

Robert R. Walper, D.C., Chicago

Medical Practice Act Licensing and Enforcement Procedures

Illinois statutes provide for the licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to practice without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no persons shall practice medicine or any of its branches or midwifery, or any system or method of treating human ailments without the use of drugs or medicines, or without operative surgery, without a valid existing license to do so." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

Required Education

Minimum standards of professional education: 2 years' course of instruction in a college of liberal arts or its equivalent, or in such medical college in a course of instruction in the treatment of human ailments which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months and in addition, a course of clinical training of not less than 12 months in a hospital. The college of liberal arts, medical school, and hospital must be reputable and in good standing in the judgment of the Department of Registration and Education.

All examinations provided by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches which shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of \$10.

Revocation and Suspension of License or Certificate

The Department may revoke or suspend the license, certificate, or state hospital permit of any person licensed under the Act upon any of the following grounds:

1. Conviction of procuring or attempting to procure such an abortion as was made unlawful at the time under the provisions of the Criminal Code of the State;
2. Conviction of a felony;
3. Gross malpractice resulting in permanent injury or death of a patient; or engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;

4. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of a financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;
5. Habitual intemperance in the use of ardent spirits, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties;
6. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
7. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, or to practice midwifery, or in passing an examination therefor, or wilful and fraudulent violation of the rules and regulations of the department governing examinations;
8. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or of the efficacy or value of one's medicine, treatment or remedy therefor;
9. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
10. Revocation or suspension of a medical license in a sister state, which revoked or suspended license was the basis of the licensee's obtaining a license in this State."

Rules and Regulations Adopted for the Administration of the Illinois Medical Practice Act, Effective March 18, 1955

RULE 1—ACCREDITED COLLEGES OF MEDICINE AND SURGERY

Medical colleges having rules and curricula commensurate with and equivalent to the rules and curricula of the Colleges of Medicine of the University of Illinois, will be considered for accreditation by the Department of Registration and Education.

RULE II—ACCREDITED COLLEGES TEACHING SYSTEMS OF TREATING HUMAN AILMENTS WITHOUT THE USE OF DRUGS OR MEDICINE AND WITHOUT OPERATIVE SURGERY.

A professional college or institution teaching a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be deemed reputable and in good standing in

the judgment of the Department upon submission of proof of the following requirements:

(a) That a Dean or other Executive Officer, employed on a full-time basis supervises the students and curriculum.

(b) That the faculty is comprised of graduates in their specialty from recognized professional colleges or institutions.

(c) That the faculty is organized and each department has a director, professors, associate professors and assistant professors, each responsible to his superior for his instruction in the particular subject he teaches.

(d) That, annually, a catalogue or brochure is published setting forth the requisites for admission to the college, tuition rates, courses offered, dates of sessions, schedule of classes, requirements for graduation, a roster of the undergraduate students and a roster of the last graduating class. The catalogue or brochure shall contain a list of the departments of the school, the titles of the personnel and a brief summary of each person's qualifications. The curriculum shall include, but not be limited to, four academic years' instruction in the following subjects:

(1) Anatomy

- (a) Embryology
- (b) Histology
- (c) Neuro-anatomy

(2) Physiology and Chemistry

(3) Pathology and Bacteriology

(4) Diagnosis

- (a) Physical
- (b) Differential
- (c) Laboratory

(e) That suitable buildings provided with laboratories equipped for instruction in anatomy, chemistry, physiology, pathology, bacteriology and other areas of learning necessary to the due course of study prescribed by these rules; and that a laboratory equipped with supplies, models, manikins, charts, stereopticon, roentgen-ray and other special apparatus used in teaching the system to treat human ailments without the use of medicine and operative surgery, be provided.

(f) That a working library, easily accessible to students, is maintained from at least 9 a.m. to 5 p.m., with a librarian in constant attendance. The library shall contain a standard medical dictionary, the modern text and reference books, and the files of leading periodicals dealing with the particular system of treating human ailments without the use of medicine and operative surgery.

(g) That the college or institution requires all students to furnish, before matriculation, satisfactory proof of the preliminary education required by the Medical Practice Act.

(h) That full and complete records are kept showing the credentials for admission, attendance, grades and financial accounts of each student.

(i) That admission of transfer students will be limited to honorably dismissed students from another approved college or institution teaching the

same system. The transcript of record obtained directly from the transferring school shall be kept on file. It shall be the duty of a college or institution to furnish such a transcript for the benefit of a student subject to honorable dismissal. No credit shall be given a transferred student for final or "senior year" work or for any courses taken by correspondence.

(j) That students shall start class attendance within one week of the start of each session. That credit for completion of a course will not be granted a student who failed to attend 80 per cent of the complete session of the course.

RULE III—HOSPITALS APPROVED FOR INTERNSHIP.

1. A hospital shall, in the judgment of the Department be deemed reputable and in good standing for training interns and intern services when it meets the following standards:

(a) General hospital of 100 beds' capacity, with an average of at least 60 patients daily, with rotating service.

(b) Shall contain at least the departments of internal medicine, surgery, obstetrics and pediatrics; and an organized departmentalized staff, holding meetings monthly for case reviews and study.

(c) Laboratory employing a full-time qualified technician and at least a part-time qualified pathologist, visiting the laboratory at least two days per week.

(d) Radiological department employing a qualified X-ray technician and at least a part-time qualified roentgenologist, visiting the department at least two days per week.

(e) Maintenance of an up-to-date medical library located in a suitable study room available to interns.

(f) Such hospital shall provide and furnish the Department with the names of staff members of the various departments of the hospital.

(g) The hospital, upon the completion of a course of training therein of not less than twelve months, shall issue its certificate therefor to any such intern or at the request of the Department, such certificate shall include therein, by date, the commencement and the conclusion thereof.

2. An approved internship shall consist of a twelve months' rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties.

In the event an applicant has received training in excess of the twelve months' period specified by the Medical Practice Act, and if this be in an institution approved by the Department as adequate for specialty training; and if the applicant has received certification by a recognized Medical Specialty Board, and has had two or more years' specialty practice or Military Service; such training and practice may be accepted as the equivalent of a rotating internship.

Any applicant who shall have completed twelve months of clinical training in a hospital, as required

by Section 5-1(b) of the Medical Practice Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard.

RULE IV—APPLICATION FOR EXAMINATION

An applicant for examination for licensure to practice medicine in all of its branches, or any system of treating human ailments without the use of drugs or medicine and without operative surgery, must make application on forms furnished by the Department at least fifteen days prior to the examination and present, in addition:

(a) Recommendations from two Illinois licentiates, or if recommendations are from non-resident practitioners, they must be countersigned by Illinois licentiates who know the original signers.

(b) A recent photograph, passport size, signed by applicant and the two persons licensed to practice the system of treatment of human ailments for which the applicant is seeking a license. A duplicate photograph must be presented with the card of admission at the examination.

(c) The original diploma of graduation from the professional college in which the applicant completed his course of training, or, in lieu of presenting the diploma with the application, the applicant may present it at the examination.

(d) A certified copy of secondary school and professional school studies to be mailed direct to the Department by the schools attended or by the professional schools where the applicant completed the required course of study.

(e) Proof of completion of a rotating internship of twelve months in an approved hospital for applicants seeking admission to examination for license to practice medicine in all of its branches; and, in the case of graduates of medical colleges in countries other than the United States and Canada, who apply for examination after January 1, 1953, proof of rotating internships of one year in approved hospitals in the State of Illinois.

(f) Graduates of foreign medical colleges, after filing applications and credentials with the Department, are required to report for personal interview with the Medical Examining Committee before being admitted to examinations.

(g) Applicants who completed their medical courses in the extramural colleges of Ireland and Scotland shall not be eligible for admission to examinations for licensure under the Illinois Medical Practice Act.

(h) Graduates of European colleges or universities after January 1, 1943, with the exception of certain approved colleges in the British Isles, Denmark, Holland, Norway, Sweden and Swit-

zerland, be not accepted for admission to examinations for licensure under the Illinois Medical Practice Act.

Graduates of such European medical colleges after January 1, 1943 may be considered for admission to Illinois examinations provided they present diplomas of graduation from approved medical colleges in the United States after attendance in such colleges for at least one year; and in addition, have served rotating internships of one year in approved hospitals in the State of Illinois.

RULE V—EXAMINATIONS

1. Examinations for licensure to practice medicine in all of its branches shall be conducted in the English language and shall be in the following theoretical and practical areas of medicine:

Theoretical

Chemistry and Physiology
Anatomy and Histology
Materia Medica & Therapeutics
Pathology & Bacteriology
Diagnosis
Hygiene & Medical Jurisprudence
Obstetrics & Gynecology
Eye, Ear, Nose, & Throat
Surgery
Dermatology, Pediatrics & Neurology

Clinical

Laboratory Diagnosis
Eye, Ear, Nose, & Throat
Surgery
Medicine

2. Examinations for licensure to practice the treatment of human ailments without the use of drugs or medicine and without operative surgery shall be conducted in the English language and shall be in the following theoretical and practical subjects:

Theoretical

Chemistry & Physiology
Anatomy & Histology
Pathology & Bacteriology
Diagnosis
Hygiene & Medical Jurisprudence
Eye, Ear, Nose, & Throat
Dermatology, Pediatrics & Neurology
System of Practice
Obstetrics (for graduates of approved osteopathic colleges)

Practical

System of Practice

3. To be successful, applicants must receive general averages of 75% with no grade below 60 in the written examination, and a general average of 75% in the clinical or practical test.

Applicants applying for registration under Sections 12 and 12a of the Medical Practice Act shall be required to make general averages of 75% in the three subjects required for license to practice medicine and surgery in Illinois.

4. In case of failure in the first and second examinations applicants will be allowed credit on the following examination for all grades of 75 or more;

but in case of failure in the third examination they must retake all written subjects at each subsequent examination. It is not required that the clinical or practical part of the examination be repeated after a passing grade of 75 has been received in that part of the examination.

5. Graduates of medical colleges in the United States who apply for license to practice medicine in all of its branches shall be required to pass only a written examination; but graduates of foreign medical colleges, including those in Canada, shall be required to pass the written examination and the practical test.

Applicants who take the regular examination conducted by the Department for licenses as Physicians and Surgeons shall be excused from taking the clinical test.

6. An applicant for registration as Physician and Surgeon who has been unsuccessful in five examinations will be deemed to be eligible for further examination upon receipt of proof that he has completed one year of residency training in an approved hospital training program in the United States received subsequent to the applicant's fifth failure.

7. An applicant who has been unsuccessful in five examinations for registration as a drugless practitioner will be eligible for reexamination upon receipt of proof that he has completed a course of study of 960 hours in a school which is accredited under the Medical Practice Act. This course must be received subsequent to the applicant's fifth failure.

8. An applicant who furnished proof of a course of study of 240 hours in a school of chiropractic recognized by the Department in order to be eligible for further examination under Section 9a of the Medical Practice Act will be considered as a new applicant and his grades of 75 per cent or more will be carried over to the second and third examinations.

RULE VI—RECIPROCITY

1. Each applicant for registration through reciprocity, either for the practice of medicine in all of its branches or for the treatment of human ailments without the use of drugs or medicine and without operative surgery, filed on forms provided by the Department, will be considered on its individual merits, provided the state or territory of original licensure grants a like privilege to persons licensed in Illinois.

2. The applicant must furnish proof of at least one year's practice in the state of original licensure unless his practice was interrupted by Military Service, in which case he must file with his application a photostatic copy of his Service Record.

3. If the application is not endorsed by officers of a state or county society it must be endorsed by two Illinois licentiates who hold licenses to practice the same system or method of practice.

4. Graduates of colleges of medicine located outside of the United States or Canada shall not be accepted for licensure by reciprocity, but must pass

the regular written and clinical examination conducted by the Department.

5. Any applicant who has failed in a written examination for licensure under the Medical Practice Act will not be accepted for licensure through reciprocity.

6. Applicants for licensure through reciprocity or upon the basis of having passed the National Board Examination must pass a clinical examination.

7. Graduates of chiropractic colleges whose applications for registration in Illinois by reciprocity are approved, shall be required to pass a written examination in theory in addition to a practical test before the chiropractic examiner.

RULE VII—LICENSURE

1. An examinee who successfully completes his medical examination must secure his certificate of licensure within one year from the date of his examination.

2. The Department will not issue a duplicate certificate of registration to practice medicine in all of its branches, or to treat human ailments without the use of drugs or medicine and without operative surgery, unless proof satisfactory to the Department and the Committee is presented that the original certificate was destroyed; or in case of change of name when the original certificate is returned for cancellation, together with satisfactory legal proof of such change of name.

3. A license to practice medicine in Illinois shall be a requisite for a residency in an Illinois hospital.

RULE VIII—TEMPORARY CERTIFICATES OF REGISTRATION

1. Application must be made on forms furnished by the Department.

2. The approved hospital at which training is to be received must signify to the Department that the hospital will appoint the applicant to the graduate or specialty training in the event he receives a Temporary Certificate of Registration.

3. An approved hospital for graduate or specialty training shall be all hospitals qualified for such training in the judgment of the Department.

4. Research Fellows in Illinois hospitals required to apply for Temporary Certificates under Section 11a of the Medical Practice Act.

5. Applicants for Temporary Certificates be advised that their Temporary Certificates are given with the understanding that they are not to be considered or used as a basis of application for permanent registration under the Medical Practice Act of the State of Illinois. Any application for permanent registration under such Act will be processed under the provisions of the Act and the rules and regulations of the Department of Registration and Education as applied to all other applicants seeking permanent registration in Illinois.

6. A person who has a pending application to take the examination may be issued a Temporary Certificate, but in such event, he is not admissible to the examination until after he completes the course for which a Temporary Certificate is sought.

7. A person who leaves a residency program be-

fore its completion may be admitted to the examination, but in such event, he will not be eligible for another Temporary Certificate if he should fail the examination and thereafter apply for another Temporary Certificate.

8. A person who completes a course of residency training under a Temporary Certificate and thereafter takes the examination and fails may be issued a Temporary Certificate to pursue another program of training and Rules 6 and 7 will then apply.

RULE IX—LIMITED LICENSES TO PRACTICE IN STATE HOSPITALS

1. Each application made on forms provided by the Department will be considered on its own merits.

2. The State Hospital at which the applicant will practice under the supervision of a medical officer, shall signify to the Department that the hospital will appoint the applicant in the event he received a Limited License.

3. Any applicant for a Limited License who has failed in more than three examinations for licensure under the Illinois Medical Practice Act shall not be eligible for a Limited License.

Other Examining Boards

Other examining boards operating under the jurisdiction of the Department of Registration and Education are:

Chiropodists

Dr. Charles H. Delano, Springfield
Dr. Theodore S. Hollingsworth, Oak Lawn
Dr. R. G. Keeley, Centralia

Optometrists

Dr. C. W. Duncan, Rockford
Dr. James K. Finley, Deatur
Dr. Thomas M. McGuire, Chicago
Dr. Clarence J. Strobel, Chicago
Dr. Wayne B. Cox, Edwardsville

Dentists

Dr. Eugene E. Ausbrook, East St. Louis
Dr. Hugh D. Burke, Dixon
Dr. Carl Greenwald, Chicago
Dr. Jacob Gerehgal, Chicago
Dr. Robert I. Humphrey, Chicago
Dr. William Podesta, Mattoon
Dr. William O. Vopata, Riverside

Physical Therapists

Miss Vilma Evans, Danville
H. Worley Kendell, M.D., Peoria
Mrs. Viola B. Newman, Hines
Kenneth Stegman, M.D., Harvey
Mrs. Lyndell D. Zimmerman, Springfield

Psychologists

Dr. Philip Ash, Chicago
Dr. Roy Brener, Hines
Dr. Ralph W. Heine, Chicago
Dr. Lloyd G. Humphreys, Urbana
Dr. Benton J. Underwood, Evanston

Pharmacists

Milton G. Christy, Pekin
Joseph Davidson, Carrollton
Dr. James E. Gearien, Chicago
Aloysius J. Neizgodski, Chicago

Harold W. Pratt, Des Plaines

Benjamin B. Rosen, Chicago

David W. Watt, Springfield

Nurses

Sister M. Amata, Chicago

Miss Carolyn M. Jurgens, Pekin

Miss Annette Lefkowitz, DeKalb

Miss Clara May Miller, Edwardsville

DEPARTMENT OF MENTAL HEALTH

401 S. Spring St., Springfield 62706

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Mortimer Brown, Ph.D., Assistant to the Director

Leo Fitzgerald, Administrative Assistant

John P. Reidy, Administrator, Public Information

Robert Dahl, Assistant Administrator, Public Information

Jewel J. Short, Supervisor, Data Processing

John B. Acheson, Special Assistant

Robert Lanier, Special Assistant

Charles W. Dixon, Special Assistant

Jerome Goldberg, Special Counsel

Raymond E. Robertson, M.D., Special Projects

Mrs. Anne Konar, Executive Secretary to the Director (Chicago)

Mrs. Betty Gum, Secretary to the Director (Springfield)

Miss Helen Loeb, Office Manager, Chicago General Office

Division of Planning and Evaluation Services

Leo Levy, Ph.D., Division Director

Ralph W. Collins, Assistant Division Director

Samuel Weingarten, Ph.D., Assistant Division Director

Warren Smith, Acting Supervisor, Statistics and Statistical Research

Allen N. Herzog, Ph.D., Chief, Data Collection and Analysis

Mary Monahan, Communications Specialist

Mrs. Elizabeth Slotkin, Chief, Program Analysis and Evaluation Research

Mr. Stanley Blaststein, Chief, Program and Liaison

Mabel Clarida, Assistant Supervisor, Statistical Research

Division of Mental Retardation Services

William Sloan, Ph.D., Division Director

Lawrence Bussard, Assistant Division Director

William K. Murphy, Consultant, Community Mental Health Clinics

Institutions

A. L. Bowen Children's Center, A. J. Shafter, Ph.D., Superintendent

Dixon State School, David Edelson, Superintendent

Lincoln State School, Joseph Albaum, M.D., Superintendent

Warren G. Murray Children's Center, Sol S. Silverman, Ph.D., Superintendent

Division of Professional Services

Robert C. Drye, M.D., Division Director
Thomas J. Clark, Chief, Activity Therapy Services
Lucy Fairbank, Assistant Chief, Activity Therapy Services
Paul A. Rittmanic, Chief, Speech and Hearing Services
Mrs. Louise A. Meyer, R.N., Assistant Chief, Nursing Service
Mrs. Annette Calloway, Chief, Psychiatric Social Work
Glen Allison, Assistant Chief, Psychiatric Social Work
Mrs. Margaret Diamond, Assistant Chief, Psychiatric Social Work
Abel Ossorio, Ph.D., Chief, Psychology Service
Rudyard Propst, Chief, Rehabilitation Service
Lyman Samo, Chief, Special Education Service
Ira D. Cravens, Chief, Veterans' Services
Paul Hletko, M.D., Chief, Medical Service
Arthur L. Magill, M.D., C.M., Special Assistant, Medical Standards & Hospital Accreditation
Paul F. Cole, Supervising Pharmacist
Paul Hletko, M.D., Forensic Psychiatry
Frederick Plotke, M.D., Chief, Public Health Service
A. A. Kaluzny, M.D., Tuberculosis Control
C. P. Maculuso, Chief, Clinical Laboratories
Miss Jane Phillips, Chief, Volunteer Services

Division of Comprehensive Mental Health Services

Zones

ROCKFORD: Norris Hansell, M.D., Zone Director
H. Douglas Singer Zone Center, 4402 North Main St., Rockford
CHICAGO: Arthur Woloshin, M.D., Zone Director
Charles F. Read Zone Center, 4200 Oak Park Ave., Chicago
CHICAGO: Bernard Rubin, M.D., Zone Director
John J. Madden Zone Center, Hines
PEORIA: Thomas T. Tourlentes, M.D., Zone Director
George A. Zeller Zone Center, 43227 N. University St., Peoria
SPRINGFIELD:
Andrew McFarland Zone Center, R.R. 4, Springfield
DECATUR-CHAMPAIGN: Lewis Kurke, M.D., Zone Director, 44 Main St., Champaign
Adolf Meyer Zone Center, R.R. 1, Decatur
Herman M. Adler Zone Center, S. First St., R.R. 2, Champaign
CARBONDALE: Robert C. Steck, M.D., Zone Director
Anna State Hospital, Anna

Hospitals and Clinics

Alton State Hospital, Abraham Simon, M.D., Superintendent
Anna State Hospital, Robert C. Steck, M.D., Superintendent
Chicago Mental Health Center, Kalman Gyarfas, M.D., Superintendent

Chicago State Hospital, J. Herbert Maltz, M.D., Superintendent
East Moline State Hospital, Konstantin Dimitri, M.D., Superintendent
Elgin State Hospital, Ernest S. Klein, M.D., Superintendent
Galesburg State Research Hospital, Thomas T. Tourlentes, M.D., Superintendent
Illinois Security Hospital, Bert Rednour, Superintendent
Jacksonville State Hospital, Sophie Leschin, M.D., Superintendent
Kankakee State Hospital, Gabriel Misevic, M.D., Superintendent
Manteno State Hospital, Richard J. Graff, M.D., Superintendent
Peoria State Hospital, Henry D. Staras, M.D., Superintendent
Tinley Park State Hospital, John L. Cutler, M.D., Superintendent

Community Services

Charles R. Meeker, Chief
B. W. Tucker, Chief, Mental Health Education
Charles R. Hurst, Assistant Chief, Mental Health Education
Joseph B. Lehmann, Consultant, Community Mental Health Clinics
Catherine Morgan, Supervisor, Licensed Private Facilities

Interstate Services

Muriel Rietz, Chief

Alcoholism Programs

Richard F. Cook, M.D., Chief
William Becker, Assistant Chief
Gerard Littman, Warren Clinic
Peoria State Hospital, Intensive Treatment Unit

Medical Center Complex

Institute for Juvenile Research

John E. Halasz, M.D., Acting Director
Noel Jenkin, Ph.D., Director of Research
Downtown Research Branch
William Healy School
Zone Programs, Children's Clinical Services, Norman J. Booth, Administrator

Illinois State Pediatric Institute

Herbert J. Grossman, M.D., Director
H. David Mosier, M.D., Director of Research

Illinois State Psychiatric Institute

Lester H. Rudy, M.D., Director
Robert C. Drye, M.D., Director of Education

Division of Research Services

Percival Bailey, M.D., Division Director
Leon White, Administrator, Mental Health Fund
Program-Staff Training

Division of Personnel Services

Don O'Donnell, Division Director
Leslie T. Thornton, Assistant Division Director (Operations)

Division of General Services

Robert H. Sipes, Deputy Director, Physical Plant Services
E. F. Merten, Deputy Director, Administrative Services
Frank F. Campbell, Deputy Director, Reimbursement Service

Statutory Boards

1. Board of Mental Health Commissioners

Alex Elson, Chicago, Chairman
Emmet F. Pearson, M.D., Springfield
Rabbi Ralph Simon, Chicago
John Adam Zvetina, Chicago
Mrs. James Holland, Rockford
Curtis Small, Harrisburg
Mrs. L. Trimble Steinbrecher, Chicago, Executive Secretary

2. Psychiatric Training and Research Authority

Roy R. Grinker, M.D., Chicago, Chairman
William H. Haines, M.D., Chicago, Secretary
Paul C. Bucy, M.D., Chicago
Paul E. Neilson, M.D., Chicago
Ernest A. Haggard, Ph.D., Chicago
Jules H. Masserman, M.D., Evanston
Samuel A. Kirk, Ph.D., Urbana
Ex-Officio—Harold M. Visotsky, M.D., Director of Mental Health; Alex Elson, Chairman, Board of Mental Health Commissioners; Herbert J. Grossman, M.D., Director Illinois State Pediatric Institute; Lester H. Rudy, M.D., Director, Illinois State Psychiatric Institute
Percival Bailey, M.D., Chicago, Executive Secretary

Statutory Board Administrative Appointment

Psychiatric Advisory Council

Benjamin Boshes, M.D., Evanston, Chairman
H. H. Garner, M.D., Chicago, Vice Chairman
Roy R. Grinker, M.D., Chicago
John F. Kenward, M.D., Chicago
Gerhart Piers, M.D., Chicago
Melvin Sabshin, M.D., Chicago
Ex-Officio—Harold M. Visotsky, M.D., Director of Mental Health
Percival Bailey, M.D., Chicago, Executive Secretary

Advisory Committee Administrative Appointment

1. Advisory Board to Division of Alcoholism

Marvin F. Burt, Freeport, Chairman
Paul B. Musgrove, Peoria, Secretary
J. Milton Guy, Chicago
George E. Moredock, Jr., Chicago
James H. Oughton, Jr., Dwight
Jackson A. Smith, M.D., Chicago
Guy A. Renzaglia, Carbondale
Paul Hletko, M.D., Chicago

2. Committee on Chest Diseases

Edward A. Piszecek, M.D., Hinsdale, Chairman
William Adams, M.D., Chicago
Kenneth G. Bulley, M.D., Aurora
Clifton Hall, M.D., Springfield
Roger A. Harvey, M.D., Chicago
William Lees, M.D., Chicago
Dan Morse, M.D., Peoria
Herman C. Rogers, M.D., Mt. Vernon
Darrell H. Trumpe, M.D., Springfield
George C. Turner, M.D., Chicago
Ex-Officio—Harold M. Visotsky, M.D., Director of Mental Health; A. A. Kaluzny, M.D., Public Health Service, Department of Mental Health

3. Advisory Committee on Grants to Local Communities for Mental Health Services

Mrs. Bernice T. Van der Vries, Evanston, Chairman
Mrs. W. J. Bryan, Rockford
Rt. Rev. Msgr. William J. Cassin, Springfield
Louis deBoer, Chicago
Robert L. Farwell, Chicago
Vernon F. Frazee, Springfield
The Very Rev. Gordon E. Gillett, Peoria
Rabbi Joseph L. Ginsberg, Highland Park
Donaldson F. Rawlings, M.D., Springfield
Mrs. H. Langdon Robinson, Springfield
Groves B. Smith, M.D., Alton
Harry Wright, M.D., Metropolis

4. Institute for Juvenile Research Advisory Council

Val Cox, Collinsville, Chairman
Mrs. James Errant, Elgin, Vice Chairman
John J. Bresee, Champaign
Rt. Rev. Msgr. William J. Cassin, Springfield
Rep. Frances L. Dawson, Evanston
James Doores, M.D., Galesburg
Mrs. Grace Duff, Cairo
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Robert Fielding, M.D., Chicago
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Milo Pritchett, East St. Louis
Lawrence K. Schnadig, Highland Park
Norman C. Sleezer, Freeport
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DEPARTMENT OF PUBLIC HEALTH

State Office Bldg., Springfield

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E. L. Wittenborn, M.P.H., Assistant to the Director
Edward Press, M.D., M.P.H., Medical Assistant to the Director

Division of General Administration

E. L. Wittenborn, Chief

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Accounting and Finance—R. T. Malone, Chief
Health Education—Lynford L. Keyes, Chief

Nursing—Pearl H. Ahrenkiel, Chief
Grace Musselman, Assistant Chief
Mildred Moore, Occupational Nursing
Statistics—E. L. Wittenborn, Acting Chief
Don D. Vance, Administrative Officer
Leo A. Ozier, Deputy State Registrar
Clyde A. Bridger, Chief Statistician
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1919 W. Taylor St., Chicago 60612

Division of Dental Health

William J. Greck, D.D.S., M.P.H., Chief

Division of Hospitals and Chronic Illness

R. F. Sondag, M.D., M.P.H., Chief

Bureaus of:

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Cancer Control Section—R. F. Sondag, Chief;
Edith Heide, Nursing Consultant on Chronic
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Consultant

GERIATRICS

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Hospital and Medical Facilities Survey and
Construction Program—George A. Lindsley
Hospital Licensing Program—George A. Lind-
sley
Hospital Accounts Analyst Service—Robert
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Hospital Maternity Study Program—Alice S.
Flesch
Civil Defense Emergency Hospital Program—
Walter E. Hedrick

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tion
Grover C. Papp, Supervisor of Common Carriers
of Grade A Products
Roy Fairbanks, Supervisor of I.M.S. Program

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Richard A. Morrissey, Assistant Chief

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Diagnostic Services—Mary Louise Brown, Chief

Laboratory Evaluation—Herbert E. McDaniels,
Chief

Sanitary Bacteriology—J. C. McCaffrey, Chief

Toxicology—Frank F. Fiorese, Chief

Virus Diseases and Research—Richard Morrissey

Laboratories:

Main Laboratory
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126½ N. Fifth St., Springfield
Springfield Sanitary Bacteriology Laboratory
Robert M. Scott
6th Floor, Capitol Bldg., Springfield
Carbondale Laboratory
Nathan Nagle
Oakland & Chautauqua Sts., Carbondale
Champaign Laboratory
Viola M. Michael
505 S. Fifth St., Champaign
Chicago Laboratory
George F. Forster
1800 W. Fillmore St., Chicago
East St. Louis Laboratory
Charles S. Puntney
414 Missouri Ave., East St. Louis
Rock Island Laboratory
Bettie Anne Muffley
121 Fourth Ave., Rock Island

Division of Preventive Medicine

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Norman J. Rose, M.D., M.P.H., Assistant Chief

Bureaus of:

Epidemiology—Norman J. Rose, Chief
Section on Veterinary Public Health—Paul R.
Schnurrenberger, Chief Public Health Veteri-
narian
Hazardous Substances and Poison Control —
Norman J. Rose, Chief
Maternal and Child Health—D. F. Rawlings,
Chief
School Health—D. F. Rawlings, Chief
Caroline Austin, Vision Conservation Coordi-
nator
Raymond J. Bernero, Hearing Conservation
Coordinator
Helen H. Natwick, Consultant Nurse

Division of Sanitary Engineering

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Verdun Randolph, Assistant Chief
R. S. Nelle, Water Resources Engineer

Bureaus of:

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Public Water Supplies—William J. Downer,
Chief
Radiological Health and Air Pollution Control—
Robert R. French
Special Services—Eugene S. Clark, Chief
Stream Pollution—D. B. Morton
Chicago Office—Sanitary Water Board
Benn J. Leland, Engineer-in-Charge

Division of Tuberculosis Control

Clifton Hall, M.D., M.P.H., Chief

Chicago State Tuberculosis Sanitarium

Herbert Neuhaus, M.D., Medical Director and Superintendent

Mt. Vernon State Tuberculosis Sanitarium

Herman C. Rogers, M.D., Medical Director and Superintendent

Division of Local Health Services

Charles F. Sutton, M.D., M.P.H., Chief

Claire E. Healey, M.D., M.P.H., Assistant Chief

Sections on:

Civil Defense Medical Self-Help Training—

Walter E. Hedrick, Civil Defense Coordinator

Community Health Services Promotion—

Harold K. Fuller, Head

Illinois Statewide Public Health Committee—

Harold K. Fuller, Executive Secretary

Regional Offices

Northeastern Region (I)—William C. Spring, Jr., M.D., M.P.H., 48 W. Galena Blvd., Aurora 60504. Counties of Boone, DeKalb, Grundy, Kane, Kankakee, Kendall, LaSalle, McHenry, and Winnebago and consultation to full-time health departments of Cook, DuPage, Lake, and Will Counties; cities of Evanston and Rockford; Villages of Oak Park, Hygienic Institute of LaSalle-Oglesby-Peru, and Stickney Township Public Health District

East Central Region (II)—Huston J. Banton, M.D., M.P.H., 301 W. Birch St., Champaign 61822. Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Ford, Iroquois, Jasper, Livingston, Moultrie, and Vermilion counties and consultation to full-time health departments of DeWitt-Piatt, Effingham, McLean, and Shelby counties, and to the Champaign-Urbana Public Health District

Northwestern Region (III)—W. Keith Weeber, (Acting), 121 Fourth Ave., Rock Island 61201. Counties of Bureau, Carroll, Hancock, Henderson, Henry, Knox, Marshall, McDonough, Mercer, Ogle, Putnam, Rock Island, Stark, Stephenson, Tazewell, Warren, Whiteside, and Woodford and consultation to full-time health departments of Jo Daviess, Lee, and Peoria counties and to the city of Peoria

West Central Region (IV)—W. M. Talbert, M.D., M.S.P.H., 521 State Office Bldg., Springfield 62706. Counties of Bond, Brown, Calhoun, Cass, Christian, Clinton, Fayette, Greene, Jersey, Logan, Macoupin, Madison, Mason, Menard, Pike, St. Clair, Sangamon, Schuyler, and Scott and consultation to full-time health departments of Adams, Fulton, Macon, Montgomery, and Morgan counties, and the East Side Health District of Canteen-Centreville-East St. Louis-Stites townships.

Southern Region (V)—Elvin L. Sederlin, M.D., P.O. Box 22, Carbondale 62902. Counties of Clay, Edwards, Hamilton, Jefferson, Marion,

Monroe, Perry, Randolph, Richland, Wabash, Washington, and Wayne and consultation to full-time health departments of Gallatin-Saline-White, Franklin-Williamson, Jackson, Lawrence, Hardin-Johnson-Massac-Pope, and Alexander-Pulaski-Union counties.

Flora Suboffice, Southern Region—Elvin L. Sederlin, M.D., City Hall, Flora 62839. Counties of Clay, Edwards, Jefferson, Marion, Richland and Wayne.

County and Multiple-County Health Departments

Adams County, Wayne Messick, M.P.H., 333 N. 6th, Quincy 62301

Cook County, John B. Hall, M.D., M.P.H., 1425 S. Racine Ave., Chicago 60608
North District, 1755 Oakton St., DesPlaines 60018
South District, 51 E. 154th St., Harvey 60426
Southwest District, 5410 W. 95th St., Oak Lawn 60453

West District, 1907-09 Rice St., Melrose Park 60160

DeWitt-Piatt Bi-County, Lelia V. Hyde, R.N., 122 E. Main St., Clinton 61727

Piatt County, Courthouse, Monticello 61856

DuPage County, Charles A. Lang, M.D., M.P.H., 222 E. Willow Ave., Wheaton 60187

Effingham County, Peter C. Supan, M.D., M.P.H., 112 E. Section Ave., Effingham 62401

Egypton (Gallatin-Saline-White Counties) Ann E. Clarke, M.D., 1333 Locust St., Eldorado 62930

White County, 110 E. Robinson, Carmi 62821

Gallatin County, Courthouse, Shawneetown 62984

Franklin-Williamson Bi-County, David P. Richerson, M.D., M.P.H., 217 E. Broadway, Johnson City 62951

Franklin County, 226 N. Main, Benton 62812

Fulton County, Wilma Sturgeon, R.N., 31 S. Main St., Canton 61520

Jackson County, Harold H. Rohrer, M.D., M.P.H., 1015½ Chestnut St., Murphysboro 62966

Jo Daviess County, Albert L. Hildinger, M.D., 311 S. Main St., Galena 61036

Lake County, Arthur G. Baker, M.D., M.P.H., 2307 Grand Ave., Waukegan 60085

West Suboffice, 330 N. Milwaukee Ave., Libertyville 60048

Lawrence County, Maxine Jackman, R.N., Courthouse, Lawrenceville 62439

Lee County, Robert C. Miles, D.D.S., M.P.H., 316 W. Third St., Dixon 61021

Macon County, Leo Michl, Jr., 1085 S. Main St., Decatur 62521

McLean County, Joseph E. Beasley, M.D., M.P.H., 401 W. Virginia Ave., Normal 61761

Montgomery County, Willis L. Whitlock, Box 149, Hillsboro 62049

Morgan County, Rosario T. Sison, M.D., 234½ W. State St., Jacksonville 62650

Peoria County, Fred Long, M.D., M.P.H., 2114 N. Sheridan Rd., Peoria 61604

Quadri-County

(Hardin-Johnson-Massac-Pope Counties), Harry Wright, M.D., M.P.H., Box 437, Goleonda 62939
Massac County, Courthouse, Metropolis 62960
Johnson County, Vienna 62995
Hardin County, Gross Bldg., Elizabethtown 62931
Shelby County, Peter C. Supan, M.D., M.P.H., 123 N. Broadway, Shelbyville 62565

Tri-County

(Alexander-Pulaski-Union Counties), Genevieve Hillerman, R.N., 1115 Cedar St., Cairo 62914
Union County, Jonesboro 62952
Will County, Herbert S. Miller, M.D., M.P.H., 21 E. Van Buren St., Joliet 60431

Urban Health Departments

Champaign-Urbana Public Health District, L. L. Fatherree, M.D., M.P.H., 505 S. Fifth St., Champaign 61824
Chicago Board of Health, Samuel L. Andelman, M.D., M.P.H., 54 W. Hubbard St., Chicago 60610
East Side Health District (Canteen-Centreville-East St. Louis-Stites Townships), John J. Gregowicz, M.D., 638 N. 20th St., East St. Louis 62205
Evanston-North Shore Health Department, Allan A. Filek, M.D., M.S.P.H., Box 870, Evanston 60204
Hygienic Institute (LaSalle-Oglesby-Peru), Arlington Ailes, M.D., M.P.H., LaSalle 61301
Oak Park Department of Public Health, Herbert Ratner, M.D., Box 31, Oak Park 60303
Peoria Department of Health, Fred Long, M.D., M.P.H., 2116 N. Sheridan Rd., Peoria 61604
Rockford Department of Public Health, Arlo J. Anderson, City Hall Bldg., Rockford 61104
Stickney Township Public Health District, Gene J. Franchi, D.D.S., M.P.H., 5635 State Rd., Oak Lawn 60459

POISON CONTROL CENTERS IN ILLINOIS

AURORA

Copley Memorial Hospital, Lincoln and Western Aves.
St. Charles Hospital, 400 New York St.

BELLEVILLE

Memorial Hospital, North Park Dr.

BERWYN

MacNeal Memorial Hospital, 3249 S. Oak Park Ave.

BLOOMINGTON

Memnonite Hospital, 807 N. Main St.
St. Joseph's Hospital, 724 W. Jackson St.

CAIRO

St. Mary's Hospital, 2020 Cedar St.

CANTON

Graham Hospital Association, 210 W. Walnut St.

CARBONDALE

Doctors Hospital, 404 W. Main St.

CHAMPAIGN

Burnham City Hospital, 311 E. Stoughton

CHESTER

Memorial Hospital, 1900 S. State St.

CHICAGO

Master Chicago Center—Presbyterian-St. Luke's Hospital, 1753 W. Congress St.

Bob Roberts Memorial Hospital, 920 E. 59th St.
Children's Memorial Hospital, 707 W. Fullerton Ave.

Cook County Hospital, 1825 W. Harrison St.

Illinois Research Hospital, 840 S. Wood St.

Mersey Hospital, 2537 S. Prairie Ave.

Michael Reese Hospital, 2839 S. Ellis Ave.

Mt. Sinai Hospital, 2750 W. 15th St.

Municipal Contagious Disease, 3026 S. California Ave.

Resurrection Hospital, 7435 W. Talcott Ave.

DANVILLE

Lake View Memorial Hospital, 812 N. Logan Ave.
St. Elizabeth's Hospital, 600 Sager Ave.

DECATUR

Decatur-Macon County Hospital, 2300 N. Edward St.

St. Mary's Hospital, 1800 E. Lake Shore Dr.

DES PLAINES

Holy Family Hospital, 100 N. River Rd.

EAST ST. LOUIS

Christian Welfare Hospital, 1509 Illinois Ave.
St. Mary's Hospital, 129 N. 8th St.

EFFINGHAM

St. Anthony's Hospital, 503 N. Maple St.

ELGIN

St. Joseph's Hospital, 277 Jefferson Ave.
Sherman Hospital, 934 Center St.

ELMHURST

Memorial Hospital of DuPage County, 315 Schiller St.

EVANSTON

Community Hospital, 2040 Brown Ave.
Evanston Hospital, 2650 Ridge Ave.
St. Francis Hospital, 355 Ridge Ave.

EVERGREEN PARK

Little Company of Mary Hospital, 2800 W. 95th St.

FAIRBURY

Fairbury Hospital, 519 S. Fifth St.

FREEPORT

Freeport Memorial Hospital, 420 S. Harlem Ave.
St. Francis Hospital, 1209 S. Walnut St.

GALENA

Northwestern Illinois Community Hospital, Summit St.

GALESBURG

Galesburg Cottage Hospital, 674 N. Seminary St.
St. Mary's Hospital, 239 S. Cherry St.

GRANITE CITY

St. Elizabeth's Hospital, 2100 Madison Ave.

HARVEY

Ingalls Memorial Hospital, 155th St. & Page Ave.

HIGHLAND PARK

Highland Park Hospital Foundation, 718 Glenview Ave.

HINSDALE

Hinsdale San. & Hospital, 120 N. Oak St.

HOOPESTON

Hoopeston Community Memorial Hospital, 6th & Orange St.

JACKSONVILLE

Passavant Memorial Area Hospital, W. Walnut St.

JOLIET

St. Joseph's Hospital, 333 Madison St.
Silver Cross Hospital, 600 Walnut St.

KANKAKEE

St. Mary's Hospital, 150 S. Fifth St.

KEWANEE

Kewanee Public Hospital, 719 Elliott St.

LAKE FOREST

Lake Forest Hospital, 660 N. Westmoreland Rd.

LA SALLE

St. Mary's Hospital, 1015 O'Connor Ave.

LIBERTYVILLE

Condell Memorial Hospital, Cleveland & Stewart
Aves.

LINCOLN

Abraham Lincoln Memorial Hospital, 315 Eighth
St.

MACOMB

McDonough Community Hospital, 525 E. Grant
Ave.

McHENRY

McHenry Hospital, 3516 W. Waukegan Rd.

MATTOON

Memorial District Hospital of Coles County,
2101 Champaign Ave.

MELROSE PARK

Westlake Hospital, 1225 Superior St.

MENDOTA

Mendota Community Hospital, Memorial Dr. &
Rt. 51

MOLINE

Moline Public Hospital, 622 Fifth Ave.

MONMOUTH

Monmouth Hospital, 515 E. Euclid Ave.

MT. CARMEL

Wabash General Hospital, Maysville Rd.

MT. VERNON

Good Samaritan Hospital, 605 N. Twelfth St.

NAPERVILLE

Edward Hospital, S. Washington St.

NORMAL

Brokaw Hospital, Franklin Ave.

OAK LAWN

Christ Community Hospital, 4440 W. 95th St.

OAK PARK

West Suburban Hospital, 518 N. Austin Blvd.

OLNEY

Richland Memorial Hospital, E. Locust St.

OTTAWA

Ryburn Memorial Hospital, 701 Clinton Ave.

PARK RIDGE

Lutheran General Hospital, 1775 Dempster St.

PEKIN

Pekin Public Hospital, 1317 Park Ave.

PEORIA

Methodist Hospital, 211 N.E. Glen Oak Ave.
Proctor Community Hospital, 5409 N. Knoxville
Ave.

St. Francis Hospital, 530 N.E. Glen Oak Ave.

PERU

Peoples Hospital, 925 W. Street

QUINCY

Blessing Hospital, 1005 Broadway
St. Mary's Hospital, 1400 Broadway

ROCK ISLAND

St. Anthony's Hospital, 767—30th St.

ROCKFORD

Rockford Memorial Hospital, 2400 N. Rockton
Ave.

St. Anthony's Hospital, 6666 E. State St.

Swedish-American Hospital, 1316 Charles St.

ST. CHARLES

Delnor Hospital, 975 N. Fifth Ave.

SPRINGFIELD

Memorial Hospital, First and Miller Sts.

St. John's Hospital, 701 E. Mason St.

URBANA

Carle Hospital, 602 W. University Ave.

Mercy Hospital, 1412 W. Park St.

WAUKEGAN

St. Therese Hospital, W. Washington St.

Victory Memorial Hospital, 1324 N. Sheridan Rd.

WOODSTOCK

Memorial Hosp. for McHenry County, 527 W.
South St.

ZION

Zion-Benton Hospital, Inc., Shiloh Blvd.

STATUTORY BOARDS AND COMMISSIONS

(Allied with Public Health Operations)

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Director of Mental Health

Director of Labor

Director of Public Health

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Committee for Revision of the Rules and Regulations for the Control of Communicable Diseases

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Charles A. Lang, M.D., Wheaton
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Fred P. Long, M.D., Peoria
Edward A. Piszczek, M.D., Forest Park

Donaldson F. Rawlings, M.D., Springfield
Eugene L. Wittenborn, Springfield

HOSPITALS

The Illinois Department of Public Health is responsible for implementing the Hospital Licensing Act, excerpts from which follow:

Section 2. The purpose of this Act is to provide for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in hospitals, and (2) for the construction, maintenance, and operation of hospitals which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospitals.

Hospital Licensing Requirements

To implement the Hospital Licensing Act, the Department of Public Health has pertinent requirements. The following cover the medical staff.

1. The medical staff shall be composed only of physicians and dentists licensed by the Illinois Department of Registration and Education in accordance, respectively, with provisions of the Medical Practice Act and Dental Practice Act.

2. The medical staff shall be organized in accordance with written bylaws, rules and regulations, approved by the governing board. The bylaws, rules and regulations shall specifically provide:

- a. for eligibility for staff membership;
- b. for such divisions and departments as are warranted, (as a minimum, Active and Consulting divisions are required)
- c. for such officers and/or committees as are warranted; (a medical records committee is required)
- d. for determination of qualifications and privileges;
- e. that medical staff meetings be held regularly, and that written minutes of all meetings be kept;
- f. for review and analysis of the clinical experience of the hospital at regular intervals—the medical records of patients to be the basis for such review and analysis;
- g. that tissue removed at operation shall be examined by a qualified pathologist and that the findings shall be made a part of the patient's medical record;
- h. for consultation between medical staff members in complicated cases; and
- i. for keeping complete medical records.

Section B. Supervision of Patient Care

All persons admitted to the hospital shall be under the professional care of a member of the medical staff.

Section C. Orders for Medication and Treatment

No medication or treatment shall be given to a patient except on the written order of a member of the medical staff.

Section D. Tissue Examination

All tissue removed at operation shall be examined by a qualified pathologist and the findings shall

be made a part of the patient's hospital medical record. A tissue committee of the medical staff is highly recommended.

Section E. Availability for Emergencies

The governing board shall provide that one or more physicians shall be available at all times for emergencies.

GENERAL HOSPITALS

(For Identification—see footnote, page 216)

ALEDO (Mercer)

Mercer County Hospital (E-60)

ALTON (Madison)

*Alton Memorial Hospital (B-181)

*St. Anthony's Hospital (B-140)

*St. Joseph's Hospital (B-170)

AMBOY (Lee)

Amboy Public Hospital (B-13)

ANNA (Union)

Union County Hospital District (F-61)

ARLINGTON HEIGHTS (Cook)

*Northwest Community Hospital (B-107)

AURORA (Kane)

*Copley Memorial Hospital (B-200)

*St. Charles Hospital (B-118)

*St. Joseph Mercy Hospital (B-112)

AVON (Fulton)

Saunders Hospital (B-24)

BEARDSTOWN (Cass)

*Schmitt Memorial Hospital (D-50)

BELLEVILLE (St. Clair)

*Memorial Hospital (B-154)

†*St. Elizabeth's Hospital (B-250)

†U. S. Air Force Hospital (J-300)

BELVIDERE (Boone)

*Highland Hospital, Inc. (B-67)

*St. Joseph's Hospital (B-100)

BENTON (Franklin)

*The Franklin Hospital (F-125)

BERWYN (Cook)

*MacNeal Memorial Hospital (B-276)

BLOOMINGTON (McLean)

*Mennonite Hospital (B-125)

*St. Joseph's Hospital (B-160)

BLUE ISLAND (Cook)

*St. Francis Hospital (B-181)

BREESE (Clinton)

*St. Joseph's Hospital (B-41)

CAIRO (Alexander)

*St. Mary's Hospital (B-124)

CANTON (Fulton)

*Graham Hospital Association (B-145)

CARBONDALE (Jackson)

*Doctors Hospital (B-98)

*Holden Hospital (B-56)

CARLINVILLE (Macoupin)

*Carlville Area Hospital (B-58)

CARMI (White)

*Carmi Township Hospital (H-61)

CARROLLTON (Greene)

Thomas H. Boyd Memorial Hospital (B-49)

CARTHAGE (Hancock)

*Memorial Hospital (B-74)

CENTRALIA (Marion)

*St. Mary's Hospital (B-117)

CHAMPAIGN (Champaign)

*Burnham City Hospital (D-175)

*Cole Hospital (C-63)

CHARLESTON (Coles)

*Charleston Community Memorial Hospital, Inc. (B-65)

CHESTER (Randolph)

Memorial Hospital (F-47)

CHICAGO (Cook)

*Alexian Brothers Hospital (B-240)

*American Hospital of Chicago (B-168)

*Augustana Hospital (B-358)

*Belmont Community Hospital (B-138)

*Bethany Brethren Hospital (B-62)

*Bethany Methodist Hospital (B-189)

*Bethesda Hospital (B-99)

*Central Community Hospital (B-93)

Cermak Memorial Hospital (D-129)

†*Chicago Wesley Memorial Hospital (B-652)

*Columbus Hospital (B-413)

†*Cook County Hospital (E-2,747)

†*Doctors General Hospital (B-174)

*Edgewater Hospital, Inc. (B-343)

*Englewood Hospital (B-159)

*Evangelical Hospital of Chicago (B-181)

*Forkosh Memorial Hospital (B-94)

*Frank Cuneo Hospital (B-174)

*Franklin Boulevard Community Hospital (B-110)

*Garfield Park Community Hospital (B-139)

†*Grant Hospital of Chicago (B-310)

*Henrotin Hospital (B-100)

*Holy Cross Hospital (B-328)

*Hospital of St. Anthony de Padua (B-208)

Ida Mae Scott Hospital (B-15)

*Illinois Central Hospital (B-301)

*Illinois Masonic Hospital (B-467)

*Jackson Park Hospital (C-184)

†*Loretto Hospital (B-169)

*Louis A. Weiss Memorial Hospital (B-250)

*Louise Burg Hospital (B-114)

*Lutheran Deaconess Hospital (B-180)

*Martha Washington Hospital (B-58)

*Mary Thompson Hospital (B-112)

†*Mercy Hospital (B-350)

†*Michael Reese Hospital and Medical Center (B-954)

Michigan Avenue Hospital (B-153)

†*Mount Sinai Hospital of Chicago (B-393)

*Northwest Hospital, Inc. (B-242)

*Norwegian-American Hospital, Inc. (B-218)

†*Passavant Memorial Hospital (B-326)

†*Presbyterian-St. Luke's Hospital (B-849)

*Provident Hospital and Training School (B-203)

*Ravenswood Hospital Association (B-275)

*Resurrection Hospital (B-252)

*Roosevelt Memorial Hospital (B-100)

*Roseland Community Hospital (B-131)

*St. Anne's Hospital (B-305)

*St. Bernard's Hospital (B-229)

*St. Elizabeth's Hospital (B-246)

*St. Frances Xavier Cabrini Hospital (B-98)

- *St. George Hospital (B-128)
- †*St. Joseph Hospital (B-484)
- *St. Mary of Nazareth Hospital (B-279)
- *South Chicago Community Hospital (B-300)
- *South Shore Hospital (B-189)
- *Swedish Covenant Hospital (B-220)
- U. S. Public Health Service Hospital (J-155)
- †*University of Chicago Hospitals and Clinics (B-711)
- †*University of Illinois Research and Educational Hospitals (I-605)
- †Veterans Administration Research Hospital (J-516)
- †Veterans Administration West Side Hospital (J-505)
- *The von Solbrig Memorial Hospital, Inc. (A-80)
- *Walther Memorial Hospital (B-169)
- *Woodlawn Hospital (B-143)
- CHICAGO HEIGHTS (Cook)
- *St. James Hospital (B-280)
- CHRISTOPHER (Franklin)
- *The Miners Hospital (B-36)
- CLIFTON (Iroquois)
- Central Hospital (B-21)
- CLINTON (DeWitt)
- John Warner Hospital (D-45)
- DANVILLE (Vermilion)
- *Lake View Memorial Hospital (B-236)
- *St. Elizabeth Hospital (B-188)
- DECATUR (Macon)
- *Decatur and Macon County Hospital (B-363)
- *St. Mary's Hospital (B-352)
- *Wabash Employees' Hospital (B-68)
- DE KALB (DeKalb)
- *DeKalb Public Hospital (D-80)
- *St. Mary's Hospital (B-50)
- DES PLAINES (Cook)
- *Holy Family Hospital (B-175)
- DIXON (Lee)
- *Dixon Public Hospital (B-120)
- DOLTON (Cook)
- Thomsen Clinic Hospital (B-6)
- DU QUOIN (Perry)
- *Marshall Browning Hospital (B-68)
- DWIGHT (Livingston)
- Veterans Administration Hospital (J-215)
- EAST ST. LOUIS (St. Clair)
- *Centreville Township Hospital (H-163)
- *Christian Welfare Hospital (B-194)
- *St. Mary's Hospital (B-360)
- EFFINGHAM (Effingham)
- *St. Anthony Memorial Hospital (B-126)
- ELDORADO (Saline)
- Ferrell Hospital (C-49)
- Pearce Hospital Foundation (B-35)
- ELGIN (Kane)
- *St. Joseph Hospital (B-150)
- *Sherman Hospital (B-268)
- ELMHURST (DuPage)
- *Memorial Hospital of DuPage County (B-316)
- EUREKA (Woodford)
- *Eureka Hospital (C-31)
- EVANSTON (Cook)
- *Community Hospital of Evanston (B-54)
- †*Evanston Hospital Association (B-440)
- *Northwestern University Student Health Service Hospital (B-44)
- *St. Francis Hospital (B-387)
- EVERGREEN PARK (Cook)
- †*Little Company of Mary Hospital (B-550)
- FAIRBURY (Livingston)
- *Fairbury Hospital (B-92)
- FAIRFIELD (Wayne)
- *Fairfield Memorial Hospital (B-94)
- FLORA (Clay)
- *Clay County Hospital (E-52)
- FREEPORT (Stephenson)
- *Freeport Memorial Hospital (B-186)
- *St. Francis Hospital (B-112)
- GALENA (Jo Daviess)
- Northwestern Illinois Community Hospital District (F-31)
- GALESBURG (Knox)
- *Galesburg Cottage Hospital (B-180)
- *St. Mary's Hospital (B-134)
- GENESEO (Henry)
- *Hammond-Henry District Hospital (F-41)
- GENEVA (Kane)
- *Community Hospital (B-122)
- GIBSON CITY (Ford)
- *Gibson Community Hospital (B-46)
- GRANITE CITY (Madison)
- *St. Elizabeth Hospital (B-220)
- GREAT LAKES (Lake)
- †U. S. Naval Hospital (J-609)
- GREENVILLE (Bond)
- *Edward A. Utlaut Memorial Hosp. (B-43)
- HARRISBURG (Saline)
- Harrisburg Hospital, Inc. (C-31)
- Harrisburg Medical Foundation (B-27)
- HARVARD (McHenry)
- *Harvard Community Memorial Hospital (F-40)
- HARVEY (Cook)
- *Ingalls Memorial Hospital (B-241)
- HAVANA (Mason)
- *Mason District Hospital (F-48)
- HAZEL CREST (Cook)
- *Hazel Crest General Hospital (B-57)
- HERRIN (Williamson)
- *Herrin Hospital (B-92)
- HIGHLAND (Madison)
- *St. Joseph's Hospital (B-133)
- HIGHLAND PARK (Lake)
- *The Highland Park Hospital Foundation (B-184)
- HILLSBORO (Montgomery)
- Hillsboro Hospital (B-68)
- HINES (Cook)
- †Veterans Administration Hospital (J-2,071)
- HINSDALE (DuPage)
- †*Hinsdale Sanitarium and Hospital (B-270)
- HOOPESTON (Vermilion)
- *Hoopeston Community Memorial Hospital (B-48)
- HOPEDALE (Tazewell)
- Hopedale Hospital (B-44)
- JACKSONVILLE (Morgan)
- *Our Savior's Hospital (B-120)
- *Passavant Memorial Area Hospital (B-150)

JERSEYVILLE (Jersey)
 *Jersey Community Hospital (F-54)
 JOLIET (Will)
 *St. Joseph Hospital (B-426)
 *Silver Cross Hospital (B-263)
 KANKAKEE (Kankakee)
 Riverside Hospital (B-122)
 *St. Mary's Hospital (B-262)
 KEWANEE (Henry)
 *Kewanee Public Hospital (B-75)
 *St. Francis Hospital (B-87)
 LA GRANGE (Cook)
 *Community Memorial General Hospital (B-225)
 LA HARPE (Hancock)
 LaHarpe Hospital (B-19)
 LAKE FOREST (Lake)
 *Lake Forest Hospital (B-96)
 LA SALLE (La Salle)
 *St. Mary's Hospital (B-120)
 LAWRENCEVILLE (Lawrence)
 *Lawrence County Memorial Hospital (E-65)
 LIBERTYVILLE (Lake)
 *Condell Memorial Hospital (B-84)
 LINCOLN (Logan)
 *Abraham Lincoln Memorial Hospital (B-102)
 LITCHFIELD (Montgomery)
 *St. Francis Hospital (B-140)
 MACOMB (McDonough)
 *McDonough District Hospital (F-104)
 Phelps Hospital (B-30)
 *St. Francis Hospital (B-50)
 MANTENO (Kankakee)
 Hillman Memorial Hospital (C-23)
 MARION (Williamson)
 *Marion Memorial Hospital (D-75)
 Veterans Administration Hospital (J-176)
 MATTOON (Coles)
 *Memorial District Hospital of Coles County
 (F-99)
 McHENRY (McHenry)
 *McHenry Hospital (B-43)
 McLEANSBORO (Hamilton)
 Hamilton Memorial Hospital (F-32)
 Vickers Memorial Hospital (C-14)
 MELROSE PARK (Cook)
 *Gottlieb Memorial Hospital (B-136)
 *Westlake Hospital (B-112)
 MENDOTA (La Salle)
 *Mendota Community Hospital (B-58)
 METROPOLIS (Massac)
 *Massac Memorial Hospital (F-42)
 MOLINE (Rock Island)
 *Lutheran Hospital (B-210)
 *Moline Public Hospital (D-240)
 MONMOUTH (Warren)
 *Monmouth Hospital (D-80)
 MONTICELLO (Piatt)
 The John and Mary E. Kirby Hospital (B-35)
 MORRIS (Grundy)
 *Morris Hospital (B-49)
 MORRISON (Whiteside)
 Morrison Community Hospital (F-32)
 MOUNT CARMEL (Wabash)
 *Wabash General Hospital District (F-79)

MOUNT VERNON (Jefferson)
 *Good Samaritan Hospital (B-110)
 Jefferson County Memorial Hospital (B-54)
 MURPHYSBORO (Jackson)
 *St. Joseph Memorial Hospital (B-63)
 NAPERVILLE (DuPage)
 *Edward Hospital (F-110)
 NASHVILLE (Washington)
 Washington County Hospital (F-36)
 NORMAL (McLean)
 *Brokaw Hospital (B-135)
 NORTHLAKE (Cook)
 Northlake Community Hospital (B-109)
 OAK LAWN (Cook)
 *Christ Community Hospital (B-334)
 OAK PARK (Cook)
 *Oak Park Hospital (B-246)
 *West Suburban Hospital (B-389)
 OLNEY (Richland)
 *Richland Memorial Hospital (E-112)
 OREGON (Ogle)
 *Warmolts Clinic (C-25)
 OTTAWA (LaSalle)
 *Ryburn Memorial Hospital (D-120)
 PANA (Christian)
 *Huber Memorial Hospital (B-70)
 PARIS (Edgar)
 *Hospital & Medical Foundation of Paris, Inc.
 (B-75)
 PARK RIDGE (Cook)
 †*Lutheran General Hospital (B-316)
 PAXTON (Ford)
 *Paxton Community Hospital (B-39)
 PEKIN (Tazewell)
 *Pekin Memorial Hospital (B-185)
 PEORIA (Peoria)
 †*The Methodist Hospital of Central Illinois
 (B-457)
 *Proctor Community Hospital (B-210)
 †*St. Francis Hospital (B-59S)
 PERU (LaSalle)
 Peoples Hospital (B-90)
 PINCKNEYVILLE (Perry)
 *Pinckneyville Community Hospital District
 (F-28)
 PITTSFIELD (Pike)
 *Illini Community Hospital (B-100)
 PONTIAC (Livingston)
 *St. James Hospital (B-65)
 PRINCETON (Bureau)
 *Perry Memorial Hospital (D-94)
 QUINCY (Adams)
 *Blessing Hospital (B-235)
 *St. Mary's Hospital (B-200)
 RANTOUL (Champaign)
 U. S. Air Force Hospital (J-200)
 RED BUD (Randolph)
 *St. Clement's Hospital (B-74)
 ROBINSON (Crawford)
 *Crawford Memorial Hospital (F-64)
 ROCHELLE (Ogle)
 *Rochelle Hospital (D-38)
 ROCKFORD (Winnebago)
 *Rockford Memorial Hospital (B-258)

St. Anthony Hospital (B-180)
 *Swedish-American Hospital (B-245)
 ROCK ISLAND (Rock Island)
 †*St. Anthony's Hospital (B-240)
 ROSICLARE (Hardin)
 *Hardin County General Hospital (B-27)
 RUSHVILLE (Schnyler)
 *Sarah D. Culbertson Memorial Hospital (F-50)
 ST. CHARLES (Kane)
 *Delnor Hospital (B-62)
 SALEM (Marion)
 *Salem Memorial Hospital (B-41)
 SANDWICH (DeKalb)
 *Sandwich Community Hospital (B-41)
 SAVANNA (Carroll)
 Savanna City Hospital (D-36)
 SHELBYVILLE (Shelby)
 *Shelby County Memorial Hospital (B-51)
 SKOKIE (Cook)
 Skokie Valley Community Hospital (B-150)
 SPARTA (Randolph)
 *Sparta Community Hospital (F-35)
 SPRINGFIELD (Sangamon)
 †*Memorial Hospital (B-368)
 †*St. John's Hospital (B-698)
 SPRING VALLEY (Bureau)
 *St. Margaret's Hospital (B-140)
 STAUNTON (Macoupin)
 *Community Memorial Hospital (B-50)
 STERLING (Whiteside)
 *Community General Hospital (D-135)
 The Home Hospital (B-25)
 STREATOR (La Salle)
 St. Mary's Hospital (B-235)
 SYCAMORE (DeKalb)
 *Sycamore Municipal Hospital (D-70)
 TAYLORVILLE (Christian)
 *St. Vincent Memorial Hospital (B-156)
 TUSCOLA (Douglas)
 Douglas County Jarman Memorial Hospital
 (E-49)
 URBANA (Champaign)
 *Carle Memorial Hospital (B-165)
 *McKinley Memorial Hospital (I-61)
 †*Mercy Hospital (B-112)
 VANDALIA (Fayette)
 Fayette County Hospital (F-102)
 WATSEKA (Iroquois)
 *Iroquois Hospital (B-71)
 WAUKEGAN (Lake)
 *Lake County General Hospital (E-65)
 *St. Therese Hospital (B-280)
 Victory Memorial Hospital (B-333)
 WEST FRANKFORT (Franklin)
 UMWA Union Hospital (B-38)
 WHITE HALL (Greene)
 White Hall Hospital, Inc. (B-18)
 WINFIELD (DuPage)
 Central DuPage Hospital (B-80)
 WOOD RIVER (Madison)
 *Wood River Township Hospital (H-74)
 WOODSTOCK (McHenry)
 *Memorial Hospital for McHenry County
 (B-100)

ZION (Lake)
 *Zion-Benton Hospital (C-94)

MENTAL HOSPITALS

ALTON (Madison)
 Alton State Hospital (1,371)
 ANNA (Union)
 Anna State Hospital (1,677)
 CHICAGO (Cook)
 Chicago State Hospital (3,031)
 Illinois State Psychiatric Institute (360)
 DANVILLE (Vermilion)
 Veterans Administration Hospital (J-1,729)
 DOWNEY (Lake)
 Veterans Administration Hospital (J-1,473)
 EAST MOLINE (Rock Island)
 East Moline State Hospital (1,373)
 ELGIN (Kane)
 Elgin State Hospital (4,035)
 GALESBURG (Knox)
 *Galesburg State Research Hospital (1,813)
 JACKSONVILLE (Morgan)
 Jacksonville State Hospital (2,346)
 KANKAKEE (Kankakee)
 Kankakee State Hospital (3,259)
 MANTENO (Kankakee)
 Manteno State Hospital (5,522)
 MENARD (Randolph)
 Illinois Security Hospital (365)
 PEORIA (Peoria)
 *Peoria State Hospital (1,794)
 TINLEY PARK (Cook)
 Tinley Park State Hospital (480)

PRIVATE MENTAL SANITARIA

AURORA (Kane)
 *Mereyville Sanitarium (B-216)
 BATAVIA (Kane)
 Bellevue Place (C-50)
 CHICAGO (Cook)
 *Fairview Sanitarium (C-150)
 *Pinel Hospital (B-65)
 *Ridgeway Hospital (B-75)
 DES PLAINES (Cook)
 *Forest Hospital (C-90)
 ELGIN (Kane)
 Resthaven Sanitarium (C-100)
 FOREST PARK (Cook)
 *Riveredge (C-269)
 JACKSONVILLE (Morgan)
 The Norbury Hospital (C-50)
 WINNETKA (Cook)
 *North Shore Hospital (C-100)

STATE SCHOOLS FOR MENTALLY DEFECTIVE

CENTRALIA (Marion)
 Warren G. Murray Children's Center (750)
 CHICAGO (Cook)
 Illinois State Pediatric Institute (585)
 DIXON (Lee)
 Dixon State School (3,235)
 LINCOLN (Logan)
 Lincoln State School (3,801)

HOSPITALS WITH SPECIAL TYPE OF SERVICE

		Type of Service
AURORA (Kane)	Kane County Springbrook Sanitarium (E-57)	TB
CAIRO (Alexander)	Alexander County Tuberculosis Hospital (E-45)	TB
CASEYVILLE (St. Clair)	Pleasant View Sanatorium (E-78)	TB
CHICAGO (Cook)	*Booth Memorial Hospital (B-25)	Maternity
	*Charles H. and Rachel M. Schwab Rehabilitation Hospital (B-61)	Rehabilitation
	*Chicago Eye, Ear, Nose and Throat Hospital (C-37)	EENT
	*Chicago State Tuberculosis Sanitarium (I-400)	TB
	*The Children's Memorial Hospital (B-231)	Pediatric
	Haleo Sanitarium, Inc. (C-10)	Alcoholic
	Illinois Children's Hospital-School (I-92)	Rehabilitation, Pediatric
	*Illinois Eye and Ear Infirmary (I-122)	EENT
	Illinois Visually Handicapped Institute (I-52)	Legally Blind
	*LaRabida Jackson Park Sanitarium (B-91)	Pediatric, Chronic
	*Martha Washington Hospital (B-50)	Alcoholic
	*Municipal Contagious Disease (D-125)	Contagious Disease
	*Municipal Tuberculosis Sanitarium (D-1,209)	TB
	*Rehabilitation Institute of Chicago (B-65)	Rehabilitation
	St. Vincent's Infant Hospital (B-50)	Pediatric
	*Shriners Hospital for Crippled Children (B-68)	Orthopedic, Pediatric
DANVILLE (Vermilion)	Vermilion County Tuberculosis Dispensary and Hospital (E-34)	TB
DECATUR (Macon)	*Macon County Tuberculosis Sanatorium (E-75)	Nursing Home
DeKALB (DeKalb)	DeKalb Public Hospital (D-10)	Chronic
DWIGHT (Livingston)	The Keeley Institute (C-20)	Alcoholic
EDWARDSVILLE (Madison)	Madison County Sanatorium (E-90)	TB
HINSDALE (Cook)	*The Suburban Cook County Tuberculosis Sanitarium District (G-205)	TB
JACKSONVILLE (Morgan)	Oaklawn, Morgan County Tuberculosis Sanatorium (E-40)	TB
JOLIET (Will)	Sunny Hill Sanatorium (E-60)	TB
MACKINAW (Tazewell)	Oak Knoll Sanatorium (E-40)	TB
MOOSEHEART (Kane)	Mooseheart Hospital (B-50)	Pediatric
MOUNT VERNON (Jefferson)	*Mount Vernon State Tuberculosis Sanitarium (I-125)	TB
NORMAL (McLean)	Fairview, McLean County Tuberculosis Sanatorium (E-32)	TB
OAK FOREST (Cook)	Oak Forest Hospital (E-2,432)	Chronic, Rehabilitation

OTTAWA (LaSalle)	Highland Sanatorium and Convalescent Home of LaSalle County (E-82) Ottawa General Hospital (C-44)	TB, Nursing Home Chronic
PEORIA (Peoria)	*Peoria Municipal Tuberculosis Sanitarium (D-94)	TB
PONTIAC (Livingston)	Livingston County Sanatorium (E-50)	TB
QUINCY (Adams)	Hillcrest, Adams County Tuberculosis Sanatorium (E-38)	TB
ROCKFORD (Winnebago)	Rockford Municipal Tuberculosis Sanitarium (D-99)	TB, Nursing Home
ROCK ISLAND (Rock Island)	*Rock Island County Tuberculosis Sanatorium (E-71)	TB
SPRINGFIELD (Sangamon)	*St. John's Sanatorium (B-125)	TB
URBANA (Champaign)	Outlook Champaign County Tuberculosis Sanatorium (E-26)	TB
WAUKEGAN (Lake)	*Lake County Tuberculosis Sanatorium (E-90)	TB
WEDRON (LaSalle)	St. Joseph's Health Resort and Sanitarium (B-94)	Medical- Chronic

The hospitals marked with an asterisk () are those which are accredited by the Joint Commission on Accreditation of Hospitals as of Dec. 31, 1964.

The presence of a hospital on this list means it has complied in the main with the standards of the Joint Commission on Accreditation of Hospitals as compiled over the years by the medical and hospital professions. The standards are minimal and it is hoped hospitals will make every effort to exceed them.

Hospitals with less than 25 beds are not eligible for accreditation. Inquiries about this listing or hospital accreditation should be directed to the office of the Joint Commission on Accreditation of Hospitals at 201 E. Ohio St., Chicago 60611.

†Dagger indicates general hospitals having psychiatric units licensed by the Illinois Department of Mental Health. All other mental facilities are licensed and/or operated by this department (federal hospitals excluded).

Number in parenthesis indicates number of beds in hospital. Initial preceding number refers to the type of control, as follows:

- A — Corporation
- B — Non-profit association or corporation
- C — Privately owned and operated
- D — City
- E — County
- F — Hospital District
- G — Sanitarium District
- H — Township
- I — State
- J — Federal

DIRECTORY OF LICENSED HOMES

The following list of homes licensed by the Illinois Department of Public Health (as of June 1964) is divided into three sections: nursing homes, sheltered care homes, and homes for the aged. Ownership of these homes may be individual, partnership, corporation for profit, non-profit corporation, government, or trust-endowment.

NURSING HOMES

Nursing home accreditation has been undertaken by the National Council on Accreditation of Nursing Homes established by the American Medical Association and the American Nursing Home Association. Dr. H. Close Hesseltine, past president of the Illinois State Medical Society, is its chairman.

Since the program is relatively new, many nursing homes in Illinois have had no chance to apply for accreditation. Hopefully, many will be accredited in the near future.

Under the current standards, accreditation is granted at three levels:

a. Intensive Nursing Care Facility—Nursing service shall be under the supervision of a registered professional nurse and a registered professional nurse shall be on duty at all times.

b. Skilled Nursing Care Facility—Nursing service shall be under the supervision of a registered nurse. A registered professional nurse shall be in charge of patient care for a minimum of five days, 40 hours per week. In addition, at least one licensed nurse shall be on duty at all times.

c. Intermediate Care Facility—Nursing service shall be under the supervision of a licensed nurse who will be on duty five days per week, with a minimum of 8 hours each day. In addition, there shall be a night attendant awake and fully dressed.

Accredited facilities in the following list are indicated by a letter corresponding to the above descriptions.

ALBION (Edwards County)

Rest Haven Manor
120 W. Main St.

ALEDO (Mercer County)

Mercer County Nursing Home
Rt. 4
Twilight Haven
303 E. Seventh St.

ALHAMBRA (Madison County)

Haven of Rest*

ALTON (Madison County)

College Avenue Nursing Home
920 College Ave.
Main Street Nursing Home*
1216 Main St.
Mather-Yinger Nursing Home*
2349 Virden St.
Riverview Nursing Home*
440 Jefferson St.
Villa Terrace Nursing Home*
510 Seminary Sq.

AMBOY (Lee County)

Forman Nursing Home
339 N. Mason Ave.

ARCOLA (Douglas County)

Fishel Nursing Home
129 N. Pine St.

ARLINGTON HEIGHTS (Cook County)

Arlington Heights Rest Home*
414 N. Vail St.

Thorsen's Nursing Home*

R.R. 2, 2105 N. Chestnut Rd.

AROMA PARK (Kankakee County)

Campbell Nursing Home*
Fourth St.

ARROWSMITH (McLean County)

DeArms Nursing Home
W. Crosson St.

ARTHUR (Moultrie County)

The Arthur Home*
423 Eberhardt Dr.

ATLANTA (Logan County)

Atlanta Nursing Home
Chatham St.
Bartmann Nursing Home*
R.R. 1

AUGUSTA (Hancock County)

M. Ranek Nursing Home*
E. Main St.

AURORA (Kane County)

Aurora Borealis, Inc.
1601 N. Farnsworth
Colonial Nursing Home
422 N. Lake

BARRINGTON (Cook County)

Barrington Rest Home, Inc.*
145 W. Main St.

BARRY (Pike County)

Barry Nursing Home*
780 Grand St.
Churchill Nursing Home
1038 Pratt St.

BARTONVILLE (Peoria County)

Martin's Convalescent Home
10 McClure Ct.

BATAVIA (Kane County)

Kane County Home
Averill Rd.

BEARDSTOWN (Cass County)

Boyd Nursing Home, Inc.
209-215 W. Third St.
Brierly House Nursing Home
604 State St.

Parkview Nursing Home
903 E. Third St.

BEAVERVILLE (Iroquois County)

Haven of Rest Nursing Home*

BELLEVILLE (St. Clair County)

Atkinson Nursing Home
514 S. Jackson St.
Herald Nursing Home
506 Court St.
Hillcrest Nursing Home
420 Mascoutah Ave.
Memorial Nursing Home*
4315 Memorial Dr.
Rest Haven Old Folks Home
44th St. and N. Belt West

- BELLWOOD (Cook County)
Elizabeth Van Gehr Nursing Home
209 S. 22nd Ave.
- BELVIDERE (Boone County)
Maple Crest Nursing Home
Boone County Home
R.R. 1, Rt. 76
Sutton's Nursing Home*
226 N. State St.
- BEMENT (Piatt County)
Bement Rest Haven*
101 S. Sangamon St.
- BENTON (Franklin County)
Franklin Hospital Skilled Nursing Care Unit
201 Bailey Ln.
Linwood Nursing Home, Inc.
N. Main and Mitchell Sts.
Rest Haven Nursing Home*
418 W. Webster
- BERWYN (Cook County)
Fairfax Geriatric & Convalescent Center
3601 S. Harlem Ave.
R. N. Convalescent Home*
6918 Windsor Ave.
- BLANDINSVILLE (McDonough County)
Newland Nursing Home*
- BLOOMINGDALE (DuPage County)
Elaine Boyd Creche
267 E. Lake St.
Mark Lund Hilltop, Inc.
158 Prairie St.
- BLOOMINGTON (McLean County)
(b) Heritage Manor*
Walnut at Clinton Blvd.
Maple Grove Nursing Home
S. Main Street Rd.
Nel-Dor Arms Nursing Home*
1116 E. Lafayette St.
Twin City Nursing Home
22 White Pl.
- BLUE ISLAND (Cook County)
Bel-Air Nursing Home
2418 W. 127th St.
Blue Island Nursing Home
2427 W. 127th St.
Burr Oaks Nursing and Convalescent Center
2426 Burr Oaks Ave.
Stocker's Nursing Home
2346 Union St.
- BLUFORD (Jefferson County)
Schumm Nursing Home
- BRADLEY (Kankakee County)
The Hallmark House
700 N. Kinsie
- BROOKFIELD (Cook County)
Brookfield Nursing and Convalescent Home
9128 W. 31st St.
Hill Haven Nursing Home
4548 Deyo
- BUNKER HILL (Macoupin County)
Tower View Nursing Home No. 1
403 Morgan St.
- BURNHAM (Cook County)
The Homestead
14500 Manistee Ave.
- BUSHNELL (McDonough County)
The Elms
McDonough County Home
Heron Nursing Home*
708 N. Dean St.
- CAMP POINT (Adams County)
Grandview Manor, Inc.
205 E. Spring St.
- CANTON (Fulton County)
Canton Nursing Home, Inc.*
N. Main St.
Sherwood Nursing Home
914 S. Main St.
- CARLINVILLE (Macoupin County)
Joiner Nursing Home
706 N. Oak St.
Lake View Nursing Home
R.R. 3
Lee Nursing Home*
334 Orient St.
Macoupin County Nursing Home
R.R. 2
Scherba's Nursing Home
817 N. High St.
Weatherford Nursing Home
318 Buchanan St.
Woodlawn Aeres Convalescent and
Nursing Home*
P.O. Box 268
- CARMI (White County)
White County Nursing Home
R.R. 3
Wilmar Restorium, Inc.
College Blvd.
- CARROLLTON (Greene County)
Tower View Nursing Home No. 2
626 Maple Ave.
- CARTHAGE (Hancock County)
Margaret Ranck Nursing Home
140 W. Main St.
- CASEY (Clark County)
Casey Nursing Home*
N. 10th St.
Rude's Goodwill Home
208 W. Main St.
- CASEYVILLE (St. Clair County)
Caseyville Nursing Home*
321 O'Fallon St.
- CENTRALIA (Marion County)
Centralia Fireside House, Inc.
1030 E. McCord St.
Centralia Nursing Home*
620 E. Broadway
Jackson's Nursing Home
230 N. Cherry St.
- CHAMPAIGN (Champaign County)
American Manor Convalescent Home*
1002 W. Church St.
(c) Greenbrier Manor*
1915 S. Mattis
Leonard Nursing Home, Inc.
618 W. Church
Oliver Nursing Home
1102 W. Church St.

CHARLESTON (Coles County)

Adkins Nursing Home*
 849 C St.
 Charleston Nursing Home
 216 Fifth St.
 Hilltop Nursing Home, Inc.*
 635 Division St.
 Oakwood Convalescent Home
 1041 Seventh St.
 Rennels' Nursing Home
 214 Fifth St.
 Wilson-Kaley Nursing Home*
 1501 18th St.

CHERRY VALLEY (Winnebago County)

Cherry Valley Rest Home
 Box 123

CHESTER (Randolph County)

Three Springs Lodge*
 R.R. 1

CHICAGO (Cook County)

A-1 Nursing Home, Inc.*
 4247 N. Hazel
 A-1 Nursing Home, Inc.
 4249 N. Hazel
 Addison Manor, Inc.*
 3526 N. Reta Ave.
 Albany Park Kosher Nursing Home, Inc.
 3418 W. Ainslie
 All American Nursing Home*
 5440-52 N. Broadway
 Alshore House
 2840 Foster Ave.
 Anna Hadley Nursing Home
 3209 W. Douglas Blvd.
 Arthur W. Devermann Residence
 5746 N. Sheridan Rd.
 Austin Congress Nursing Home*
 901 S. Austin Blvd.
 Beachview Convalescent Home, Inc.*
 6346 N. Sheridan Rd.
 Beacon Hill Nursing Home
 4530 N. Beacon St.
 Beckwith Nursing Home*
 3240 W. Washington Blvd.
 Bell Nursing Home
 11079 S. Bell Ave.
 Belmont Rest Home, Inc.*
 1936 W. Belmont
 Beverly Hills Nursing Home
 10347 Longwood Dr.
 Birchwood Beach Convalescent Home No. 1*
 7350 N. Sheridan Rd.
 Birchwood Beach Convalescent Home No. 2
 7364 N. Sheridan Rd.
 Bryn Mawr House, Inc.*
 6141 N. Pulaski Rd.
 Burke Nursing Home
 11840 S. Western Ave.
 Burnside Rest Home
 9435 Langley Ave.
 Carmen Manor
 1470 W. Carmen Ave.
 Cobb and Coleman Home
 4533 W. Washington Blvd.

Colonial Towers Nursing Home*

6032 N. Kenmore Ave.
 Davis Nursing Home, Inc.
 725-29 Waveland Ave.
 Dearborn House, Inc.*
 2400 S. Dearborn St.
 Douglas Park Nursing Home
 1518-22 S. Albany Ave.
 Doyle's Nursing Home
 9626 S. Vincennes Ave.
 Edgewater Manor*
 5838 N. Sheridan Rd.
 Elizabeth Olivia Home
 3952 S. Ellis Ave.
 Elsa S. Long Convalescent Home*
 5250-5256 N. Sheridan Rd.
 Elston Home, Inc.*
 4340 N. Keystone Ave.
 Englewood Rest Haven, Inc.*
 7253 Yale Ave.
 Fargo Beach Home, Inc.
 7445 N. Sheridan Rd.
 Farwell Beach Convalescent Home, Inc.
 1145 W. Farwell Ave.
 Feinstein's Nursing Home, Inc.
 5960 N. Sheridan Rd.
 Fontainebleau Manor, Inc.
 6318 N. Winthrop Ave.
 Fox River Pavilion
 4700 N. Clarendon Ave.
 Fullerton Convalescent Home, Inc.
 1400 W. Monroe St.
 (b) Garden View Home, Inc.*
 6450 N. Ridge Ave.
 Garfield Nursing Home
 3834 W. Washington Blvd.
 Golden Age Home
 4542 N. Malden Ave.
 Granville Manor
 1021 Granville Ave.
 Hampden Manor*
 2724 N. Hampden Ct.
 Harmon-Bragg Nursing Home No. 1
 6455 S. Kimbark Ave.
 Harmon-Bragg Nursing Home No. 2*
 6463 S. Kimbark Ave.
 Hastings Nursing Home
 7241 S. Princeton Ave.
 Hearthside Nursing Home, Inc.*
 1223 W. 87th St.
 Hollywood Convalescent Home, Inc.*
 1054 W. Hollywood Ave.
 Howard Convalescent Home, Inc.
 6522 S. Harvard Ave.
 Ivory Nursing Home*
 5839 S. Calumet Ave.
 Johnson Nursing Home, Inc.*
 3321 W. Fulton St.
 Johnson Rehabilitation Nursing Home, Inc.
 3456 W. Franklin Blvd.
 (b) Kenmore House*
 5517 N. Kenmore Ave.
 Ken-Rose Rest Home*
 6255 N. Kenmore Ave.

- Kostner Manor*
1617 N. Kostner Ave.
Lake Shore Nursing Home, Inc.*
7230 N. Sheridan Rd.
Lakeside Nursing Home
6330 N. Sheridan Rd.
Lake View Manor Rest Home
2824 N. Sheridan Rd.
Lehrer Nursing Home, Inc.
4636 N. Beacon St.
Lincoln Park Home
2042 N. Orleans St.
Linderman Nursing Home, Inc.*
3311 W. Monroe St.
Malden Nursing Home, Inc.*
4616 N. Malden St.
Maple Nursing Home
4743 W. Washington St.
Mark Howard Home*
4938 Drexel Blvd.
Martha Washington Manor, Inc.*
4515 S. Drexel Blvd.
Melbourne Convalescent Home*
4625 N. Racine Ave.
Midwest Rest Haven*
310 S. Hamlin Ave.
Miller Nursing Home
3256 W. Douglas Blvd.
Misericordia Home
2916 W. 47th St.
Monterey Convalescent Home*
4616 S. Drexel Blvd.
Monterey Convalescent Home*
1919 S. Prairie Ave.
Montgomery Convalescent Home
5956 S. Wabash Ave.
Mortkowiez Kosher Nursing Home
4851 N. Rockwell Ave.
Mt. Pisgah Nursing Home
4220-28 S. Champlain Ave.
Nesbitt Home*
943 W. Foster Ave.
North Shore Rest Haven, Inc.*
7428 N. Rogers Ave.
Ogden Park Convalescent Home*
6617-25 S. Racine Ave.
Panenka Nursing Home
1901 S. Lawndale Ave.
Park House
2320 S. Lawndale Ave.
Patterson Convalescent Home*
3242 W. Maypole Ave.
Pedraza Nursing Home, Inc.
3230 W. Washington St.
Pedraza Nursing Home, Inc.
3234 W. Washington St.
Peyton Convalescent Home
4541 S. Michigan Ave.
Rabbi Meisels Convalescent Home, Inc.*
4900 N. Bernard Ave.
Rosewood Terrace Rest Home, Inc.
6668 N. Damen Ave.
Royal Manor*
5640 N. Sheridan Rd.
St. Michael's Rest Haven, Inc.*
4815 S. Drexel Blvd.
Schiller Rest Home, Inc.*
1428 W. Jarvis
Shorecrest Convalescent Home, Inc.
7331 N. Sheridan Rd.
Shore View Manor Convalescent Home, Inc.*
2719 E. 75th St.
South Shore Kosher Rest Home, Inc.
7325 S. Exchange Ave.
South Shore Pavilion
7750 South Shore Dr.
(b) Sovereign Rest Home*
6159 N. Kenmore Ave.
Stern's Convalescent Home, Inc.*
730 Waveland St.
Stewart Nursing Home, Inc.
6710 S. Stewart Ave.
Sunnyside Nursing Home
4537 N. Greenview Ave.
Sunset Nursing Home, Inc.
7270 South Shore Dr.
Thorndale Manor
1020 W. Thorndale Ave.
Uptown Convalescent Home*
4646 N. Beacon St.
Vincennes Manor*
4724 S. Vincennes Ave.
Waveland Manor, Inc.
3662 N. Lake Shore Dr.
Wellington Plaza
504 W. Wellington Ave.
Wendt Nursing Home
5914 N. Sheridan Rd.
West Side Nursing Home, Inc.*
1900 S. Kedzie Ave.
Westwood Manor, Inc.
2444 W. Touhy Ave.
Whitehall Convalescent and Nursing
Home, Inc.*
1901 N. Lincoln Park West
Winerest Nursing Home*
6326 N. Winthrop Ave.
Winston Manor Convalescent and
Nursing Home, Inc.*
2155 W. Pierce Ave.
Wrightwood Nursing Home, Inc.*
2732 Hampden Ct.
CHICAGO HEIGHTS (Cook County)
Bel-Air Nursing Home No. 2
309 W. 16th St.
CLAYTON (Adams County)
Padgett Nursing Home
Box 166
CLINTON (DeWitt County)
DeWitt County Nursing Home
R.R. 1
Pine Crest Nursing Home*
North Center Limits
COAL VALLEY (Rock Island County)
Oak Glen Nursing Home
COLCHESTER (McDonough County)
Helton Nursing Home
S. East St.

COLLINSVILLE (Madison County)
 Pleasant Rest Nursing Home
 614 Summit

CREAL SPRINGS (Williamson County)
 Creal Springs Nursing Home
 S. Line St.

CRESTWOOD (Cook County)
 Fraley Convalescent Home
 4330 Midlothian Turnpike Rd.
 Rest Haven Illiana Christian
 Convalescent Home, Inc.
 13259 S. Central Ave., Palos Heights

CRETE (Will County)
 Skylane Acres*
 Rt. 1, Box 359-20

DANVILLE (Vermilion County)
 Colonial Manor, Inc.
 629 Warrington Ave.
 Danville Care, Inc.
 1701 N. Bowman Ave.
 Margenette*
 503 W. North St.
 Nance Nursing Home
 622 Bryan Ave.
 Vermilion County Nursing Home
 R.R. 1, Box 13

DECATUR (Macon County)
 (a) Americana Nursing Center of Decatur, Inc.*
 444 W. Harrison St.
 Lakeshore Manor*
 1293 34th St.
 Macon Acres, Macon County Home
 R.R. 1, Box 192
 Macon County Tuberculosis Sanatorium
 & Nursing Home
 400 W. Hay
 Mary Ann's
 640 W. Main St.
 Muirheid Nursing Home
 231 E. Condit St.
 Strong's Nursing Home
 936 N. Church St.
 Wakefield Aged Retreat Home
 1504 N. Water St.
 Wakefield Rest Home
 800 W. McKinley Ave.
 West View Nursing Home
 628 W. Main St.

DeKALB (DeKalb County)
 DeKalb County Nursing Home
 Sycamore Rd., R.R. 23

DesPLAINES (Cook County)
 (a) Brookwood Convalescent Center*
 Lyman and Dempster Sts.
 (c) DesPlaines Convalescent Home
 866 Lee St.
 Golf Road Pavilion*
 9555 W. Golf Rd.
 (b) Graceland Home of DesPlaines, Inc.
 545 Graceland Ave.

DIXMOOR (Cook County)
 Dixmoor Villa Convalescent Home, Inc.*
 Norris and Davis Sts.

Starnes Nursing Home*
 14434 S. Hoyne Ave.

DIXON (Lee County)
 Lee County Nursing Home
 R.R. 4
 Orchard Glen, Inc.
 141 N. Court
 Rest Haven Convalescent Home
 204 E. Third St.

DOLTON (Cook County)
 Miller's Rest Home
 158th and Cottage Grove Ave.

DOWNER'S GROVE (DuPage County)
 Highland House Nursing Home, Inc.
 35th St. and Highland Ave.

DUNDEE (Kane County)
 Bowes Nursing Home
 305 Oregon St.
 Gregg Nursing Home
 417 E. Hill St.

EAST ST. LOUIS (St. Clair County)
 Carr Nursing Home*
 3110 Bond Ave.
 Doctors' Convalescent Center
 421 E. Broadway
 Fletcher Ann Convalescent Home
 2640 St. Louis Ave.
 Lively Nursing Home
 1303 Baugh Ave.

EDWARDSVILLE (Madison County)
 Madison County Nursing Home
 Main St.

EFFINGHAM (Effingham County)
 Marks Nursing Home
 406 E. Jefferson

ELDORADO (Saline County)
 Eldorado Nursing Home, Inc.*
 Third and Locust Sts.
 Good Shepherd Nursing Home No. 1
 First and Jasper Sts.

ELGIN (Cook County)
 Little Angels
 Rt. 3, Rt. 58

ELGIN (Kane County)
 Daybreak Nursing Home
 420 Douglas Ave.
 Elgin-Bowes Nursing Home
 105 N. Gifford St.
 Hillcrest Convalescent Home, Inc.
 4 N. Jackson St.
 Isabelle Rest Home
 104 S. State St.
 Mary Margaret Manor
 134 N. McLean Blvd.
 Oliver Nursing Home, Inc.*
 325 Watch St.
 Raloff Nursing Home
 316 Division St.
 Restville House
 443 E. Chicago St.

ELMHURST (DuPage County)
 Elmhurst Nursing Home
 200 E. Lake St.

ELMWOOD (Peoria County)
 Elm Haven, Inc.*

- EL PASO (Woodford County)
 El Paso Nursing Home
 404 E. First St.
 Lewis Nursing Home, Inc.*
 487 Elmwood Ct.
 Tobein Nursing Home, Inc.*
 469 Elmwood Ct.
- EVANSTON (Cook County)
 Broad Nursing Home
 2001 Orrington Ave.
 Broad Nursing Home
 1840 Asbury Ave.
 Evanston Convalescent Center, Inc.
 1300 Oak Ave.
 Evanston Rest Home, Inc.
 1729 Livingston St.
 Klinger Nursing Home
 2306 Ridge Ave.
 Pembridge House, Inc.*
 1406 Chicago Ave.
 Ridge Crest Home
 1708 Ridge Ave.
 (a) Three Oaks Nursing Center
 500 Asbury Ave.
- EVERGREEN PARK (Cook County)
 Bel Air Nursing Home
 9307 S. Crawford Ave.
 Evergreen Gardens, Inc.*
 9125 S. Crawford Ave.
 Evergreen Manor Nursing Home
 3327 W. 95th St.
 Gunderson's Convalescent & Nursing Home
 2701 W. 95th St.
 Peace Memorial Home
 10124 S. Kedzie Ave.
- FAIRBURY (Livingston County)
 Mae F. Harris Home
 410 E. Oak St.
- FAIRFIELD (Wayne County)
 Fair Haven
 507 W. Elm St.
- FARMER CITY (DeWitt County)
 Farmer City Nursing Home, Inc.
 326 Clinton Ave.
- FLORA (Clay County)
 Raber Nursing Home
 402 E. Fourth St.
- FREEBURG (St. Clair County)
 Marian Nursing Home
 406 State St.
- FREEPORT (Stephenson County)
 Benjamin Stephenson Nursing Home*
 Walnut Rd.
 Ortiz Nursing Center*
 565 N. Turner St.
 Van Buren Nursing Home
 503 N. Van Buren
- GALATIA (Saline County)
 Good Shepherd Nursing Home No. 2
 Main and Cross Sts.
- GALENA (Jo Daviess County)
 Sunny Hill Nursing Home
 513 Bouthillier St.
- GALESBURG (Knox County)
 Americana Nursing Center of Galesburg
 270 E. Losey at Kellog
 Campbell Nursing Home
 731 N. Seminary
 Harvey Nursing Home
 774 N. Broad St.
 Powell Nursing Home
 620 S. Academy
 Schrader Nursing Home
 490 N. Cherry
 Sheltering Arms Nursing Home
 618 Michigan Ave.
- GALVA (Henry County)
 Wasson Nursing Home
 309 N.E. First St.
- GENESEO (Henry County)
 Gradert's Nursing Home
 426 W. First St.
 Henry County Convalescent Home
 R.R. 4
- GENEVA (Kane County)
 Anna Baum Home
 115 Campbell St.
 Marian Manor Nursing Home
 28 N. First St.
- GENOA (DeKalb County)
 Villa Nursing Home*
 121 Main St.
- GIBSON CITY (Ford County)
 Gibson Community Hospital Annex
 430 E. 19th St.
 Gibson Manor, Inc.
 525 Hazel Dr.
 Williams Nursing Home
 315 N. Guthrie St.
- GILLESPIE (Macoupin County)
 Tower View Nursing Home No. 3
 703 S. Second St.
- GLEN ELLYN (DuPage County)
 Manor Convalescent Home, Inc.
 818 DuPage Rd.
- GLENVIEW (Cook County)
 Whitehaven Acres, Inc.
 Greenwood Ave. and Melody Ln.
- GODFREY (Madison County)
 Blu-Fountain Manor, Inc.*
 Rt. 100
- GRANITE CITY (Madison County)
 The Colonnades
 1 Colonial Dr.
- GRAYVILLE (White County)
 Baldwin Nursing Home, Inc.*
 305 W. North St.
- GREENFIELD (Greene County)
 Cedar Knoll Nursing and Convalescent Home
 711 Bluff St.
- GREENVILLE (Bond County)
 Bourgeois Nursing Home, Inc.*
 100 W. College St.
 Pacette Nursing Home
 102 E. College St.
- GRIDLEY (McLean County)
 Dowell Nursing Home*
 202 W. Sixth St.

- HALF DAY (Lake County)
Pine Manor
Rt. 1, Box 185
- HAMPSHIRE (Kane County)
Hampshire Nursing Home
Jackson and Warner Sts.
Lydia Nursing Home
25 W. Jackson St.
- HARDIN (Calhoun County)
Montreat Nursing Home
R.R. 2, Box 152
- HARRISBURG (Saline County)
Bacon's Nursing Home*
Box 269, N. Granger St.
County Club Manor*
1000 W. Sloan
- HARTLAND (McHenry County)
Valley Hi Nursing Home
McHenry County Home
- HARVARD (McHenry County)
Harvard Rest Home
210 E. Front St.
- HARVEY (Cook County)
St. Jude Nursing Home
14660 S. Western Ave.
- HAVANA (Mason County)
Havana Nursing Home
224 W. Mound St.
Reid Nursing Home, Inc.
121 S. Orange St.
- HERRIN (Williamson County)
Hampton Nursing Home*
321 S. 14th St.
Mattingly Nursing Home, Inc.*
920 S. 14th St.
- HICKORY HILLS (Cook County)
Villa Marie Nursing Home, Inc.
9246 S. Roberts Rd.
- HIGHLAND (Madison County)
Helvetia Nursing Home
2510 Lemon Street Rd.
Miles Nursing Home
817 Ninth St.
- HIGHLAND PARK (Lake County)
Abbott House
405 Central Ave.
- HIGHWOOD (Lake County)
(c) Pavilion of Highland Park*
50 Pleasant Ave.
- HILLSBORO (Montgomery County)
Hillsboro Nursing Home*
624 S. Main St.
- HILLSIDE (Cook County)
Oakridge Convalescent Home
323 Oakridge Ave.
- HINSDALE (DuPage County)
Griffith Nursing Home
Garfield St. and Plainfield Rd.
Oaks Nursing Home
Rt. 83 and 91st St.
Shank Rest Home
525 W. Ogden Ave.
- HOPEDALE (Tazewell County)
(a) Hopedale Nursing Home
Second St.
- INA (Jefferson County)
Underwood Nursing Home
3 Elm St.
- IRVING (Montgomery County)
Rest Haven Nursing Home, Inc.*
- JACKSONVILLE (Morgan County)
Lasley Nursing Home*
844 W. College Ave.
Meline Nursing Home No. 1*
606 N. Church St.
Meline Nursing Home No. 2*
616 N. Church St.
Meline Nursing Home No. 3*
612 N. Church St.
Modern Care Convalescent and Nursing Home*
1500 W. Walnut
Smith Nursing Home*
221 E. Beecher St.
- JERSEYVILLE (Jersey County)
Garnet Nursing Home
602 W. Pearl St.
Green Lawn Nursing Home
518 S. State St.
Waters Nursing Home
408 N. Giddings St.
- JOLIET (Will County)
Americana Nursing Center of Joliet*
300 N. Madison
Broadway Nursing Home
216 N. Broadway
LeSan Nursing Home
601 Campbell St.
Lincoln Nursing Home
611 E. Cass St.
Pleasant Center Nursing Home
5 S. Center St.
Sunny Hill Nursing Home
501 Ella Ave.
- JONESBORO (Union County)
Dodd Nursing Home
Jonesboro Sq.
- KANKAKEE (Kankakee County)
(a) Americana Nursing Center of Kankakee*
900 W. River Pl.
Casper Nursing Home No. 2
480 E. Oak St.
Deerwood Convalescent Home
R.R. 5, Aroma Park Rd.
- KNOXVILLE (Knox County)
Good Samaritan Nursing Home
407 N. Hebard St.
Knox County Nursing Home
St. Martha's Nursing Home, Inc.
N. Market St.
- LaGRANGE (Cook County)
LaGrange Colonial Manor*
339 N. Ninth Ave.
LaGrange Convalescent and Nursing Center
42 S. Ashland Ave.
- LAKE BLUFF (Lake County)
Hill Top Farm
502 N. Telegraph Rd.
- LAKE VILLA (Lake County)
Hampstead House*
601 S. Rt. 59

- Lake Villa Nursing Home*
P.O. Box 87, Cedar Ave.
Venetian Manor Convalescent Home
Rt. 2 on Rt. 132, Grand Ave.
LAKE ZURICH (Lake County)
Bee Dozier's Maple Hill Nursing Home, Inc.*
P.O. Box 288
LANSING (Cook County)
Tri-State Manor Nursing Home
250—175th St.
LAWRENCEVILLE (Lawrence County)
Shidler Nursing Home*
1022 Twelfth St.
LEBANON (St. Clair County)
Bohannon Nursing Home, Inc.
404 S. Fritz St.
LENA (Stephenson County)
Ortiz Convalescent Home*
516 Schuyler St.
LEWISTOWN (Fulton County)
Stephens Nursing Home
305 S. Main St.
LIBERTYVILLE (Lake County)
Lake County Nursing Home
1125 N. Milwaukee Ave.
Wayside Home*
214 W. Park Ave.
LINCOLN (Logan County)
Abraham Lincoln Memorial Extended Care
315 Eighth St.
Christian Nursing Home*
1507 Seventh St.
Mary Henry Nursing Home*
1700 Fifth St.
Wasson Nursing Home, Inc.*
1011 Third St.
LITCHFIELD (Montgomery County)
Friendly Haven Nursing Home*
823 Chapin St.
(e) Litchfield Nursing Home*
628 S. Illinois St.
LOCKPORT (Will County)
Oak Bluff Nursing Home
102 Bruce Rd.
LOUISVILLE (Clay County)
Hill Crest Nursing Home
Chestnut St.
MADISON (Madison County)
Madison Nursing Home
1521 Second St.
MARENGO (McHenry County)
Florence Rest Home
546 E. Grant Hwy.
MAROA (Macon County)
Villa Maria Nursing Home
125 S. Main St.
MARSHALL (Clark County)
Burnsides Nursing Home, Inc.
N. Second St.
MASCOUTAH (St. Clair County)
Grange Nursing Home
Tenth St. (R.R. 1, Box 145)
Mascoutah Nursing Home*
213 E. Church St.
- West Main Nursing Home*
1244 W. Main St.
MASON CITY (Mason County)
Christian Care Nursing Home*
705 E. Chestnut St.
MATTOON (Coles County)
Cunningham Nursing Home*
1312 Wabash Ave.
Douglas Nursing Center
State Hwy. 121W
MAYWOOD (Cook County)
(c) Lendino Nursing Home, Inc.*
1110 S. Ninth Ave.
McHENRY (McHenry County)
(c) Villa Nursing Home*
1201 W. Rocky Beach
McLEANSBORO (Hamilton County)
McLeansboro Nursing Home*
205 E. Cherry St.
MENDOTA (LaSalle County)
Sunrise Nursing Home
1201 First Ave.
MIDLOTHIAN (Cook County)
Bowman Nursing Home, Inc.
14743 S. Turner Ave.
Bowman Nursing Home, Inc., No. 1
3249 W. 147th St.
Clover Acres*
5252 W. 147th St.
Largent Convalescent Home*
4323 W. 147th St.
Maple Farm Convalescent Home*
14500 S. Long St.
MILAN (Rock Island County)
Comfort Harbor Nursing Home
114 W. Second Ave.
MINONK (Woodford County)
Kirkton Nursing Home
221 Locust St.
MOLINE (Rock Island County)
Americana Nursing Center of Moline*
833 Sixteenth St.
Fairhaven Nursing Home
2525 Ninth Ave.
MONMOUTH (Warren County)
Colonial Nursing Home, Inc.
303 E. Broadway
Monmouth Nursing Home
116 S. H St.
Warren County Nursing Home
R.R. 4
MONTICELLO (Piatt County)
Cozy Haven Nursing Home*
713 W. Bond St.
Piatt County Nursing Home
R.R. 2
MORRIS (Grundy County)
Dena Erickson Home*
916 Fremont Ave.
Grundy County Nursing Home
R.R. 4
MORRISON (Whiteside County)
Eveningside Nursing Home
509 N. Genesee St.

MORRISONVILLE (Christian County)

(c) Memorial Nursing Home*

MORTON (Tazewell County)

Morton Nursing Home

424 N. Main St.

(a) Restmor, Inc.*

925 E. Jefferson

MT. CARMEL (Wabash County)

Monticello Nursing Home, Inc.

Box 229

Wabash Nursing Home

Rt. 3

MT. STERLING (Brown County)

Barker's Nursing Home*

204-206 Railroad Ave.

Haley's Nursing Home

401 W. Main St.

Whited Nursing Home

308 N. Capitol St.

MT. VERNON (Jefferson County)

Hickory Grove Manor

8 Doctors Park Rd.

Lowry's Nursing Home*

1304 Main St.

Setzekorn Nursing Home*

1300 Broadway

MT. ZION (Macon County)

Woodland, Inc., Nursing Home*

Box 310

MOWEAQUA (Shelby County)

Moweaqua Nursing Home

MUNDELEIN (Lake County)

North Riverwood Manor, Inc.

Rt. 1, 106 Milwaukee Ave., Half Day

MURPHYSBORO (Jackson County)

Dillow Nursing Home

316 N. Ninth St.

(a) Jackson County Nursing Home

1441 N. 14th St.

Tyler Nursing Home, Inc.*

1711 Spruce St.

NAPERVILLE (DuPage County)

(b) Americana Nursing Center of Naperville*

200 Martin Dr.

Brentwood Nursing Home*

134 N. Washington St.

NASHVILLE (Washington County)

Friendship Manor, Inc.

Friendship Dr.

NILES (Cook County)

(a) Gross Point Manor

6601 Touhy Ave.

Svithiod Nursing Home

8800 Grace St.

NORMAL (McLean County)

(b) Americana Nursing Center of

Bloomington-Normal*

510 Broadway

Brokaw Nursing Home

Virginia and Franklin Sts.

NORTHBROOK (Cook County)

(a) Eden View Convalescent and

Geriatric Center*

222 Frontage Rd.

Northbrook Nursing Home & Rehabilitation
Center, Inc.*

270 Skokie Rd.

OAK LAWN (Cook County)

(b) Concord Nursing Home*

9401 Ridgeland

Doyle Nursing and Convalescent Homes, Inc.

5432 W. 87th St.

(a) Monticello Convalescent Home*

6300 W. 90th St.

Parkside Gardens Nursing Home

5701 W. 79th St.

OAK PARK (Cook County)

Oak Park Nursing Home, Inc.

637 S. Maple Ave.

Patterson Nursing & Rehabilitation Care

130 N. Austin Blvd.

Royal Oak Convalescent and Geriatric Center

625 N. Harlem Ave.

The Woodbine*

6909 W. North Ave.

ODIN (Marion County)

Wutzler Nursing Home

Kirkwood St.

Yaw Nursing Home

Laury St.

OKAWVILLE (Washington County)

Washington Springs Nursing Home

OLNEY (Richland County)

Burgin Nursing Home No. 1*

305 S. Washington St.

Burgin Nursing Manor

928 E. Scott St.

Golden Years Nursing Home*

502 S. Fair St.

Marks Nursing Home*

217 N. Fair St.

ORANGEVILLE (Stephenson County)

Krug Convalescent Home*

High St.

OREGON (Ogle County)

Eventide Nursing Home

403 S. Third St.

OTTAWA (LaSalle County)

Hassley's Health Haven

Gentleman Rd., R.R. 4

Highland Sanatorium and Convalescent

Home of LaSalle County

800 Center St.

LaSalle County Home

R.F.D. 1

Susie H. Moore Rest and Healing Home

627 Third Ave.

PALATINE (Cook County)

Aage House

234 N. Plum Grove Rd.

Bee Dozier's Palatine Nursing Home*

W. Dundee Rd.

(b) Plum Grove Nursing Home, Inc.*

24 S. Plum Grove Ave.

PALOS HILLS (Cook County)

Irwin Manor Nursing and Convalescent Home

10426 Roberts Rd.

- PANA (Christian County)
DePaepe-Ashcraft Nursing Home
10 Oak St.
- PARK RIDGE (Cook County)
(c) Park Ridge Terrace*
665 Busse Hwy.
- PAXTON (Ford County)
Ford County Nursing Home
R.R. 2
Lyons Nursing Home
440 E. Pells St.
- PEKIN (Tazewell County)
Floy's Nursing Home
803 Park Ave.
Knollcrest Nursing Home, Inc.*
Allentown Rd.
- PEORIA (Peoria County)
(b) Americana Nursing Center of Peoria*
5600 Glen Elm Dr.
Baker Nursing Home*
500-502 W. Second St.
Bel-Wood Nursing Home
7023 W. Planck Rd.
(b) High View Nursing Home*
2308 W. Nebraska St.
Mahoney Nursing Home No. 1
444 W. Second St.
Mahoney Nursing Home No. 2*
2149 N. Knoxville St.
Walker Nursing Home*
1504 W. Garden St.
- PEORIA HEIGHTS (Peoria County)
Fireside House, Inc.
1629 Gardner Ln.
- PERU (LaSalle County)
Tri City Nursing Home
2804 Sixth St.
- PETERSBURG (Menard County)
Sunny Acres
Menard County Home, Rt. 3
- PITTSFIELD (Pike County)
Couch Nursing Home
521 E. Washington St.
Couch Nursing Home No. 2
531 E. Washington St.
Pittsfield Convalescent Home*
411 W. Washington St.
- PLYMOUTH (Hancock County)
Myrtle Sapp's Nursing Home
Main St.
- PONTIAC (Livingston County)
Livingston County Nursing Home
R.R. 1
- PRAIRIE CITY (McDonough County)
Westfall K & C Nursing Home*
Reed and Union Sts.
Westfall Nursing Home*
- PRINCETON (Bureau County)
Prairie View Nursing Home
R.R. 5
- QUINCY (Adams County)
Boll Nursing Home
1029 Jersey St.
Eloise Nursing Home
1614 N. Fourth St.
- Hall Nursing Home*
1870 Vermont St.
(a) Lincoln-Terrace Nursing Home*
1315 N. Eighth St.
St. Joseph Hall
1415 Vermont St.
Theda Boll Nursing Home
438 N. Twelfth St.
- RAYMOND (Montgomery County)
Cottage Nursing Home*
W. Sparks St.
- ROANOKE (Woodford County)
Roanoke Manor, Inc.
1102 W. Randolph St.
- ROBBINS (Cook County)
Esma A. Wright Convalescent Center*
139th St. at Lydia
- ROBINSON (Crawford County)
Gowen Nursing Home
902 Mefford St.
Robinson Nursing Home*
503 E. Main St.
- ROCHELLE (Ogle County)
(b) Americana Nursing Center of Rochelle*
900 N. Third St.
- ROCK FALLS (Whiteside County)
Riverview Nursing Home
308 E. Second St.
- ROCKFORD (Winnebago County)
Alma Nelson Manor
550 S. Mulford
Americana Nursing Center of Rockford*
2313 N. Rockton
Deacon Home
611 N. Court St.
Johnson's Hill Top Nursing Home*
728 N. Court St.
Lund Nursing Home
1503 Fourth Ave.
North Rockford Convalescent Home
1925 Fremont St.
Rockford Municipal Sanitarium Nursing Home
1601 Parkview Ave.
The Restorium
2800 S. Main St.
(a) River Bluff Nursing Home
N. Main Rd.
Riverside Manor, Inc.
707 N. Riverside Blvd.
Sarver Convalescent Home, Inc.
2430 S. Main St.
- ROCK ISLAND (Rock Island County)
Mrs. Carroll's Nursing Home
4434 Seventh Ave.
Parkway Rest Home
557—30th St.
Shady Lawn Nursing Home, Inc.
1018 Twelfth St.
- ROSEVILLE (Warren County)
Roseville Nursing Home
N. Main St.
- ROSSVILLE (Vermilion County)
Hedreka Nursing Home
R.R. 2

- ROUND GROVE (Whiteside County)
Whiteside County Nursing Home
- RUSHVILLE (Schuyler County)
Hills Convalescent Home*
717 E. Adams
Snyder's Home*
135 Morgan St.
- RUTLAND (LaSalle County)
Rutland Nursing Home, Inc.
E. Front St. and Chestnut St.
- ST. ELMO (Fayette County)
Elm Haven Nursing Home*
317 Cumberland Rd.
- ST. CHARLES (Kane County)
Valley Rest Home
309 S. Sixth Ave.
- SANDWICH (DeKalb County)
Sandhaven, Inc.*
517 N. Main St.
- SAYBROOK (McLean County)
Kinsell's Nursing Home, Inc.*
205 N. Main St.
- SHANNON (Carroll County)
Johnson's Nursing Home
- SHELBYVILLE (Shelby County)
Young's Shelbyville Restorium, Inc.*
Rt. 128 North
- SHELDON (Iroquois County)
Happy Siesta Nursing Home
220 E. Center St.
- SIDELL (Vermilion County)
(c) Fairview Alliance Home*
R.R. 1
- SILVIS (Rock Island County)
Happy Haven Rest Home
118 Tenth St.
- SKOKIE (Cook County)
Old Orchard Manor
4660 Old Orchard Rd.
(c) Skokie Valley Manor, Inc.*
4600 Simpson St.
Village Nursing Home in Skokie, Inc.*
9000 Lavergne Ave.
- SMITHBORO (Bond County)
American Nursing Home
- SOUTH CHICAGO HEIGHTS (Cook County)
Sara Wolf Nursing Home*
120 W. 26th St.
- SOUTH HOLLAND (Cook County)
Colonial Convalescent Home*
549 E. 162nd St.
- SPARTA (Randolph County)
Randolph County Nursing Home
W. Belmont
- SPRINGFIELD (Sangamon County)
Americana Nursing Center of Springfield*
707 N. Rutledge
Beard Nursing Home*
925 S. Seventh St.
Carver Convalescent Home*
1527 E. Washington St.
Claudia's Nursing Home*
409 N. Grand Ave. East
Colonial Cottage
116 S. State St.
- Edwards Manor Nursing Home, Inc.*
1625 E. Edwards St.
- Hamilton Nursing Home*
925 N. Fifth St.
- Haven Nursing Home*
2301 W. Monroe
- Homestead Convalescent Home and
Nursing Residence*
127 N. Douglas Ave.
- Philips Nursing Home
630 N. Sixth St.
- Ramshaw Retirement Home No. 1*
631 N. Sixth St.
- Ramshaw Retirement Home No. 2
611 N. Sixth St.
- Ridgewood Nursing Home*
3400 Peoria Rd.
- Rutledge Manor Care Home, Inc.*
819 N. Rutledge
- Standage Nursing Home
2205 E. Capitol Ave.
- The Wrightwood
720 S. Pasfield
- STERLING (Whiteside County)
(a) Colonial Acres Rest Home*
Rt. 2
- STICKNEY (Cook County)
Pershing Convalescent Home*
3900 S. Oak Park Ave.
- STOCKTON (Jo Daviess County)
Morgan Memorial Home
501 E. Front Ave.
- STREATOR (LaSalle County)
Heritage Manor
1525 E. Main St.
Star Haven Convalescent and Nursing Home
405 N. Wasson St.
Edgetown Nursing Home
Richards and Chicago Sts.
- SULLIVAN (Moultrie County)
East View Manor Nursing Home
P.O. Box 97
Singiser Nursing Home
817 E. Jackson St.
- SUMNER (Lawrence County)
Milligan Nursing Home
Railroad St.
Red Hills Rest Haven, Inc.
Pine Lawn Addition
- SWANSEA (St. Clair County)
Castle Haven Convalescent Center
225 Castellano Dr.
- TAYLORVILLE (Christian County)
Dexheimer Nursing Home
216 E. Franklin St.
Meadow Manor*
Rt. 48 North
Johnson Nursing Home
1024 W. Park
Smith's Guest Home*
305 E. Adams St.
- TINLEY PARK (Cook County)
Kosary Convalescent Home
6660 W. 147th St., R.R. 2

McAllister Nursing Home No. 2
1834 LaVerne Rd.
TONICA (LaSalle County)
Dyer Nursing Home
Second and Elm Sts.
TOULON (Stark County)
Public Convalescent Home
219 S. Franklin St.
TREMONT (Tazewell County)
Tazewell County Nursing Home
R.R. 1
TROY (Madison County)
Rockwood Rest Home
212 N. Powell St.
TUSCOLA (Douglas County)
Martin Nursing Home*
114 E. Daggy St.
URBANA (Champaign County)
Champaign County Nursing Home
1701 E. Main St.
VANDALIA (Fayette County)
Fayette County Hospital Annex
727 W. Jackson
Fayette County Nursing Home
R.R. 3
Ted Mangner Nursing Home*
117 S. Seventh St.
VIENNA (Johnson County)
Hill View
VILLA GROVE (Douglas County)
Maple Rest Home
710 E. Elm St.
VILLA PARK (DuPage County)
Acre View Nursing Home
538 S. Villa Ave.
VIRDEN (Macoupin County)
Miller's Nursing Home*
231 E. Deane St.
VIRGINIA (Cass County)
Kirkpatrick Nursing Home
145 N. Front St.
Walker Nursing Home
530 E. Beardstown St.
WARREN (Jo Daviess County)
Daters Nursing Home
Water St.
Lahey Nursing Home
Burnett St.
Sunnyside Nursing Home
206 Lions St.
WASHBURN (Woodford County)
Atteberry Nursing Home
231 Parkside Dr.
WASHINGTON (Tazewell County)
(b) Washington Nursing Center, Inc.*
1110 New Castle Rd.
(c) Washington Home*
104 E. Holland St.
WATERLOO (Monroe County)
Monroe County Nursing Home
Illinois Ave.
WATSEKA (Iroquois County)
Iroquois Resident Home
830 S. Fourth St.

WAUKEGAN (Lake County)
Pavilion Nursing Home, Inc.*
2217 W. Washington
WAVERLY (Morgan County)
Bridges Nursing Home
200 E. State St.
WENONA (Marshall County)
Wenona Rest Haven, Inc.
Elm St.
WEST CHICAGO (DuPage County)
Hazelhurst Nursing Home, Inc.
Roosevelt and Gary Mill Rd.
Morton Manor Health Home
R.R. 1, Box 753
WHEATON (DuPage County)
DuPage County Convalescent Home
County Farm Rd.
Wheaton Health Resort, Inc.
1325 Manchester Rd.
WHITE HALL (Greene County)
Hill Top Haven*
McCarthy Ave. and U.S. Rt. 67A
WINFIELD (DuPage County)
(a) Abbey-Winfield Geriatric &
Convalescent Home
Wynwood Rd. and Shady Way
Zace Retirement Home
27 W. 141 Liberty St.
WITT (Montgomery County)
Laura Charles Nursing Home*
WOOD DALE (DuPage County)
Wood Dale Nursing Home*
140 Hemlock
WOODSTOCK (McHenry County)
Birchwood Nursing Home
R.R. 1
Woodstock Residence, Inc.*
309 McHenry Ave.
YORKVILLE (Kendall County)
Hillside Nursing and Convalescent Home, Inc.*
Rt. 34 and Game Farm Rd.
Hillside Nursing and Convalescent
Home, Inc., No. 2
Rt. 34 and Prairie Ln.
ZION (Lake County)
Parkview Nursing Home
1911—27th St.
Golden Day Nursing Home
923 Shiloh Blvd.
Zion Nursing Home
2561 Sheridan Rd.
*Member of Illinois Nursing Home Association

SHELTERED CARE HOMES

A sheltered care home is equipped and staffed to provide only personal services such as assistance with meals, dressing, bathing etc., but not nursing care.

ALEDO (Mercer County)
Fortner Sheltered Care Home
1006 E. Fifth St.
ALTON (Madison County)
Alby Street Sheltered Care Home
1912 Alby St.

Griffin Sheltered Care Home
 1914 Washington Ave.
 Mitchell Sheltered Care Home
 1800 Belle St.
 Stahl Shelter Care Home
 1414 Milton St.
ANNA (Union County)
 Dodson Shelter Care Home
 300 South St.
 Galbraith Home
 223 W. Vienna St.
 Melvin's Sheltered Care Home
 612 E. Davie St.
 Pitts Sheltered Care Home
 310 E. Davie St.
ARROWSMITH (McLean County)
 Murrell's Guest Home
ASHLAND (Cass County)
 Burch Home
ASHMORE (Coles County)
 Ashmore Estates
BARRY (Pike County)
 Tittsworth Sheltered Care Home
 Rogers St.
BELLEVILLE (St. Clair County)
 Cerneka Sheltered Care Home
 404 N. Charles St.
 Gorski Old Folks Home
 1412 W. Main St.
 Gribler Sheltered Care Home
 511 S. Charles St.
 Mil-Ran Retirement Home
 5 Gundlach Pl.
BENTON (Franklin County)
 Cockrum Sheltered Care Home
 314 S. Main St.
 Higgerson's Home
 209 N. Eighth St.
 Severin Sheltered Care Home
 105 Mill St.
 Shady Rest Sheltered Care
 114 E. Webster St.
 Wertz's Sheltered Care Home
 217 Pope St.
BLOOMINGTON (McLean County)
 Eden's Sheltered Care Home
 1108 N. Prairie St.
 Golden Age Home
 412 N. Roosevelt Ave.
 Hanson Sheltered Care Home
 909 S. Center St.
 Lowrey Shelter Care Home
 903 W. Mulberry St.
 Rusk Haven Shelter Home
 102 Greenwood Ave.
BRADLEY (Kankakee County)
 Evans Shelter Care Home
 496 S. Wabash St.
BRIGHTON (Jersey County)
 Post Sheltered Care Home
 Strack St., P.O. Box 161
BUNKER HILL (Macoupin County)
 Hammond Shelter Care Home
 512 S. Franklin

BUSHNELL (McDonough County)
 Daly's Golden Home
 257 E. Hail St.
CARLINVILLE (Macoupin County)
 Henry Sheltered Care Home
 323 Sumner St.
CAMBRIDGE (Henry County)
 Pine Lodge Home
 112 E. Center St.
CANTON (Fulton County)
 Sunset Home
 135 S. First St.
 Sunset Sheltered Care Home No. 2
 129 S. First Ave.
CASEY (Clark County)
 Rude's Goodwill Shelter Home
 110 E. Monroe St.
CENTRALIA (Marion County)
 Brewer Shelter Care Home
 603 N. Walnut St.
CHEBANSE (Iroquois County)
 Morgan Manor
 243 S. First St.
CHAMPAIGN (Champaign County)
 Painter's Sheltered Care Home
 406 S. Prairie St.
CHARLESTON (Coles County)
 Teaters Sheltered Care Home
 Fifth and Jackson Sts.
 Young Sheltered Care Home
 763 Tenth St.
CHENOA (McLean County)
 Rose Lawn Sheltered Care Home No. 2
 324 Weir St.
CHESTER (Randolph County)
 Padgett's Pot-A-Pourri Rest Home
 647 State St.
CHICAGO (Cook County)
 Jewish Peoples Convalescent Home
 6512 N. California Ave.
 Kraus Home, Inc.
 1620 W. Chase Ave.
CLIFTON (Iroquois County)
 Mary Knoll Sheltered Care Home
 195 E. Fifth St.
COBDEN (Union County)
 Tripp Sheltered Care Home
 Box 323
COLLINSVILLE (Madison County)
 Butler Home
 413 Vandalia St.
COULTERVILLE (Randolph County)
 Coulterville Sheltered Care Home
 Seventh and Cedar Sts.
DALLAS CITY (Henderson County)
 Welborn Sheltered Care Home
 69 E. Maine St.
DANVERS (McLean County)
 Holman Shelter Care Home
 300 E. Exchange St.
DECATUR (Macon County)
 Gladville Home
 1013 W. Wood St.
 Herr Shelter Care Home
 328 N. Edwards St.

- Lindsey Rest Home
737 W. Wood St.
Osborne Sheltered Care Home
1860 N. Broadway St.
DONGOLA (Union County)
Keller Sheltered Care Home
Box 634
DUQUOIN (Perry County)
Miller Sheltered Care Home
24 S. Line St.
DWIGHT (Livingston County)
Open Arms Shelter
200 N. Franklin
EAST ST. LOUIS (St. Clair County)
Carr Sheltered Care Home
3112 Bond St.
Park Retirement Home
2246 N. 57th St.
Popejoy's Retirement Home
1504 Illinois Ave.
EFFINGHAM (Effingham County)
Ireland Sheltered Care Home
111 Forest St.
Marks Sheltered Care Home
500 Clinton Ave.
ELDORADO (Saline County)
Murray Hotel
900 Fifth St.
ELGIN (Kane County)
The Oliver Annex
364 St. Charles St.
Restville House Unit 2
15-17 S. Channing St.
EL PASO (Woodford County)
Elderly Citizens Home
Main St.
ENFIELD (White County)
Fields Shelter Care Home
W. Main St.
FLORA (Clay County)
Anderson's Sheltered Care Home
201 E. Third St.
Cottengaim Shelter Care
215 W. Second St.
Ferguson Sheltered Care Home
530 W. North Ave.
Raber Sheltered Care Home
409 E. Third St.
GALESBURG (Knox County)
Barre's Sheltered Care Home
1179 E. Main St.
Clay Sheltered Care Home
319 W. North St.
The Evergreens
1188 W. Main St.
Halls Sheltered Care Home
659 N. Seminary St.
Lee's Sheltered Care Home
736 N. Kellogg St.
GOLCONDA (Pope County)
Millis Sheltered Care
Monroe St.
Rose View Sheltered Care Home
Washington and Harrison Sts.
- GRAYVILLE (White County)
Hillcrest Home
320 W. South St.
GREENUP (Cumberland County)
Peter's Sheltered Care Home
308 N. Kentucky St.
GREENVILLE (Bond County)
Hilltop House
202 N. Fourth St.
Horsfall Sheltered Care Home
201 S. Second St.
HERRIN (Williamson County)
Mattingly Sheltered Care Home
700 N. 14th
Park Avenue Sheltered Care Home
Rt. 148, P.O. Box 68
HEYWORTH (McLean County)
Lush Sheltered Care Home
303 E. Main St.
IRVING (Montgomery County)
Mi-Edd Shelter Home
JACKSONVILLE (Morgan County)
Bell Sheltered Care Home
602 Jordan St.
Blue Sheltered Care Home
506 W. Morton Ave.
Brown Sheltered Care Home
716 W. College Ave.
Hardy Sheltered Care Home
830 W. College Ave.
Hoots Rest Home
717 E. Douglas St.
Parker Sheltered Care Home
203 W. Beecher Ave.
Rosedale Sheltered Care Home
220 Brown St.
JERSEYVILLE (Jersey County)
Gibson Sheltered Care Home
301 W. Pine St.
Stark's Sheltered Care Home
600 N. Liberty St.
JOHNSTON CITY (Williamson County)
Cazaleen's Sheltered Care Home
207 E. Fifth St.
Maple House Shelter Care
207 E. Third St.
Nellie Ernfeld Home
R.R. 1
JONESBORO (Union County)
Gibbs Sheltered Care Home
204 S. Pecan St.
Henard Sheltered Care Home
204 S. Main St.
KAMPSVILLE (Calhoun County)
Smith Sheltered Care Home
KANKAKEE (Kankakee County)
Bethel Shelter Home
556 E. Oak St.
Geeding Shelter Home
139 S. Greenwood Ave.
Oaklawn Home
191 N. Washington Ave.
Oaks Shelter Home
453 E. Chestnut St.

Royal Shelter Home
195 N. Entrance Ave.

KEWANEE (Henry County)
Lofgren Duncan Manor
218 S. Tremont St.

LaHARPE (Hancock County)
Gillett Home
W. Main St.
Wells Sheltered Care Home
200 Archer Ave.

LeROY (McLean County)
LeRoy Home
902 N. Mill St.

LEXINGTON (McLean County)
Rose Lawn Shelter Care Home
207 N. Elm St.
Three Oaks Sheltered Care Home
306 W. South St.

LOUISVILLE (Clay County)
Twilight Haven
Hiriam St. & Rt. 45

LOVINGTON (Moultrie County)
Gaddis Sheltered Care Home, Inc.
240 E. State St.

MANTENO (Kankakee County)
Wooley's Home
272 W. Fourth St.

MARION (Williamson County)
Miner Shelter Care Home
205 E. Marion St.

MARSHALL (Clark County)
Dunkel Sheltered Care Home
325 S. Sixth St.
Marshall Christian Hotel
805 Archer Ave.

MARTINSVILLE (Clark County)
Glendening Home
25 S. Washington St.

McCONNELL (Stephenson County)
Mugger Sheltered Care Home
Main St.

McHENRY (McHenry County)
Shan Gra-La Sheltered Care Home
3820 W. Idylldell Rd.

METROPOLIS (Massac County)
Anderson Sheltered Care Home
205 Metropolis St.
Senior Citizens Retirement Home
308 W. Third St.

MILFORD (Iroquois County)
Golden Jubilee Home
28 S. West Ave.

MOLINE (Rock Island County)
Hendren's Sheltered Care Home
2606 Sixth Ave.
Hensley Home
1111 Fifteenth St.
Paul's Boarding Home
849 Fifteenth St.

MOMENCE (Kankakee County)
Momence Guest Haven
124 N. Maple
Momence Shelter Home
229 E. Indiana Ave.

MONMOUTH (Warren County)
Galusha Sheltered Care Home
323 N. Second St.
Watson Sheltered Care Home
215 S. Second St.

MT. CARMEL (Wabash County)
Chestnut Sheltered Care Home
218 Chestnut
Holiday Rest Home
122 E. Third St.
Ladies Lodge
318 W. Second St.
Shurtleff Annex
416 Plum St.
Shurtleff Shelter Care Cottage
429 E. Fifth St.

MT. OLIVE (Macoupin County)
Albert Sheltered Care Home
101 W. Fourth St.

MT. STERLING (Brown County)
Deluxe Care
117 E. South St.

MT. VERNON (Jefferson County)
Hearthside Sheltered Care Home
318 N. Ninth St.

MULBERRY GROVE (Bond County)
Smith's Sheltered Care Home
111 S. Maple St.

NEWTON (Jasper County)
duMont Sheltered Care Home
438 S. Lafayette St.

OBLONG (Crawford County)
Fouty's Sheltered Care Home
411 S. Garfield St.
Hart Sheltered Care
403 N. Range St.
Oblong Sheltered Care Home
106 N. Garfield St.

ODELL (Livingston County)
The Odell Shelter, Inc.
17 Henry St.

OLD MARISSA (St. Clair County)
Old Marissa Sheltered Care Home

OLNEY (Richland County)
Braden Sheltered Care
230 E. North Ave.
Marks Sunset Manor
1044 Whittle
Miller Sheltered Care Home
103 E. Lafayette St.
Rachel Moore Shelter Care
413 S. Morgan

ONARGA (Iroquois County)
Jones Sheltered Care
317 N. Walnut

OQUAWKA (Henderson County)
Oquawka Shelter Home

PALMYRA (Macoupin County)
Light House Shelter

PARIS (Edgar County)
Matthews Sheltered Care Home
414 Douglas St.
Sanders Sheltered Care Home
813 Tenbrook

PAW PAW (Lee County)
Pfeiffer Sheltered Care Home
PEORIA (Peoria County)
Senior Citizens Sheltered Care Home
302 W. Third St.
Waldo Home
405 N. Perry
PERU (LaSalle County)
Hillview Manor
2106 Market St.
PLANO (Kendall County)
Wesley Haven, Inc.
218 N. Center
PLYMOUTH (Hancock County)
Thomas Sheltered Care Home
Box 323
PONTIAC (Livingston County)
Northerest Manor
732 N. Mill St.
PRINCEVILLE (Peoria County)
Seven Oaks
Douglas and Tremont Sts.
QUINCY (Adams County)
Bacon Sheltered Care Home
1435 N. Fifth St.
Beever Sheltered Care Home
327 Elm St.
Francis Shelter Care Home
431 Locust St.
Sims Shelter House
1619 N. Fourth St.
ROCHELLE (Ogle County)
Joyce Old Folks Home
609 N. Sixth St.
ROCKFORD (Winnebago County)
Bethany House
412 N. Court St.
Lund Sheltered Care Home
1443 Fifth Ave.
Parkview Sheltered Care Home
408 N. Horsman St.
ROODHOUSE (Greene County)
Dameron Shelter Care Home
114 E. Palm St.
RUSHVILLE (Schuyler County)
Lacey's Sheltered Care Home
239 W. Clay St.
ST. ANNE (Kankakee County)
Good Sheltered Care Home
392 W. Station
Good Sheltered Care Home No. 1
391 W. Station
ST. JACOB (Madison County)
Nolan Sheltered Care Home
R.R. 1
SALEM (Marion County)
Hogge's Sheltered Care Home
521 E. Church St.
SANDOVAL (Marion County)
Finn's Sheltered Care Home
W. North Second St.
SAYBROOK (McLean County)
Maplebrook
Main St.

SESSER (Franklin County)
Nixt Sheltered Care Home
303 W. Mathew
SHELDON (Iroquois County)
Huss Sheltered Care Home
390 N. Fourth St.
SPARTA (Randolph County)
Krzebie Shelter Home
411 S. St. Louis St.
SPRINGFIELD (Sangamon County)
Gannar Cerebral Palsy Home
910 S. Second St.
Lane Bryant Retirement Home
1712 E. Washington St.
Mayol Sheltered Care Home
723 E. Reynolds St.
Peart Sheltered Care Home
1010 S. Second St.
Sunshine Guest Home
607 S. Fifth St.
Tomlin Retirement Home
609 N. Fourth St.
STOCKTON (Jo Daviess County)
Brog's Sheltered Care Haven
205 E. Benton St.
STREATOR (LaSalle County)
Hillview Sheltered Care Home
518 S. Bloomington St.
SULLIVAN (Moultrie County)
Beals Sheltered Care Home
13 S. McClellan St.
SYCAMORE (DeKalb County)
The Driscoll Home
309 N. California
THOMSON (Carroll County)
Maple Lawn Home
TILTON (Vermilion County)
Smoot Memorial Home
215 W. Sixth St.
Mrs. Etta R. Wangler Anderson
Sheltered Care Home
605 E. Fifth St.
URBANA (Champaign County)
Lustig Sheltered Care Home
904 W. Clark St.
VIRGINIA (Cass County)
Virginia Sheltered Care Home
132 E. Illini St.
WARSAW (Hancock County)
Carlson Sheltered Care Home
150 Main St.
WATSEKA (Iroquois County)
Pleasant Lodge
590 E. Grant St.
WAUKEGAN (Lake County)
Marseilles Retirement Home, Inc.
604 N. Genesee St.
WAVERLY (Morgan County)
Witt Sheltered Care Home
405 S. Miller St.
WEST FRANKFORT (Franklin County)
Peacock Sheltered Care Home
309 W. Oak St.
Rankin Sheltered Care Home
312 E. Fourth St.

WEST SALEM (Edwards County)

Golden Acres, Inc.
Wood Sheltered Care Home
609 S. Monroe

WHITE HALL (Greene County)

Bateman Sheltered Care Home
535 N. Main St.
Elliott Sheltered Care Home
601 N. Main St.
Powell Sheltered Care Home
144 E. Lincoln St.
Shanahan Sheltered Care Home
431 Centennial St.

WINCHESTER (Scott County)

Oak Rest Sheltered Care Home
206 High St.

YORKVILLE (Kendall County)

Himes Sheltered Care Home
N. Bridge St.

ZION (Lake County)

Robbins Home
3220 Emmans Ave.

HOMES FOR THE AGED

A home for the aged is operated not-for-profit under religious or fraternal auspices or under an endowment. It is primarily for persons over 60 years of age and may provide personal care only or nursing and personal care. Some of these homes for the aged provide special services over and above nursing care.

In this section, the following symbols are used: A—sheltered care facilities, B—nursing care facilities, and C—special geriatric facilities.

ALHAMBRA (Madison County)

Hitz Memorial Home—AB
Belle St.

ALTON (Madison County)

Alton Woman's Home—A
2224 State St.
The Loretto Home—A
417 Prospect St.

ARLINGTON HEIGHTS (Cook County)

Lutheran Home and Service for the Aged—AB
800 W. Oakton St.

AUBURN (Sangamon County)

Parks Memorial Home—AB
304 Maple St.

AURORA (Kane County)

Jennings Terrace—AB
275 S. LaSalle St.
Sunnymere, Inc.—AB
925 Sixth Ave.

BELLEVILLE (St. Clair County)

Meredith Memorial Home—A
Public Square
St. Elizabeth's Home for the Aged—AB
211 S. Third St.
St. Paul's Home—AB
1021 W. "E" St.

BENSENVILLE (DuPage County)

Bensenville Home Society—AB
York and Memorial Dr.

BROOKFIELD (Cook County)

The British Home—AB
31st and McCormick Ave.

CANTON (Fulton County)

Nancy and Ann Kelley Home for the Aged—A
344 W. Chestnut St.

CARLYLE (Clinton County)

St. Mary's Home for the Aged—A
501 Clinton St.

CHAMPAIGN (Champaign County)

The Garwood Home—A
1515 N. Market St.

CHESTER (Randolph County)

St. Ann's Home—B
770 State St.

CHICAGO (Cook County)

Augustana Home for the Aged—AB
7540 Stony Island Ave.

Bethany Home—AB

5015 N. Paulina St.

Bohemian Home for the Aged—AB

5061 N. Pulaski Rd.

Chicago Holland Home for the Aged—AB
240 W. 107th Pl.

Church Home for Aged Persons—AB

5435-45 Ingleside Ave.

Cosmopolitan Community Home—A

51 E. 53rd St.

Covenant Home—AB

2725 W. Foster Ave.

Drexel Home, Inc.—ABC

6140 Drexel Ave.

Fridhem Baptist Home—AB

11404 S. Bell Ave.

George J. Goldman Memorial Home for the Jewish Aged—AB

1152 W. Farwell Ave.

Home of the Association of Jewish Blind—A

3525 W. Foster Ave.

Jane Dent Home—A

4430-32 Vincennes Ave.

Jewish Home for the Aged—ABC

1648 S. Albany Ave.

Little Sisters of the Poor—AB

5148 Prairie Ave.

Methodist Old Peoples Home—AB

1415 Foster Ave.

Midwest Baptist Home, Inc.—AB

3055 W. Washington

Northwest Home for the Aged—AB

2201 N. Sacramento Ave.

Norwegian Lutheran Bethesda Home—AB

2833 N. Nordica Ave.

Norwood Park Home—AB

6016 N. Nina Ave.

The Old People's Home of the City of Chicago—AB

909 Foster Ave.

Park View Home—ABC

1401 N. California Ave.

Sacred Heart Home—AB

1550 S. Albany Ave.

St. Augustine—AB

2358 N. Sheffield Ave.

St. Joseph's Home for the Aged—AB

- 2650 N. Ridgeway Ave.
 St. Paul's House—A
 3831 N. Mozart St.
 Selfhelp Home for the Aged—A
 4941 S. Drexel Blvd.
 Society for the Danish Old People's Home—AB
 5656 N. Newcastle Ave.
 Washington and Jane Smith Home—ABC
 2340 W. 113th Pl.
- DANVILLE (Vermilion County)
 Webster Memorial Home—A
 903 N. Logan Ave.
- DECATUR (Macon County)
 Anna B. Millikin Home—A
 200 N. Oakland Ave.
- ELBURN (Kane County)
 Fellowship Deaconry—A
 526 N. Main St.
- ELGIN (Kane County)
 Oak Crest Residence—AB
 204 S. State St.
- EUREKA (Woodford County)
 Maple Lawn Homes—AB
- EVANSTON (Cook County)
 Alonzo Mather Aged Ladies Home—AB
 1615 Hinman Ave.
 The Georgian—AB
 422 Davis St.
 Homecrest Foundation—A
 1430 Chicago Ave.
 James C. King Home for Old Men—AB
 1555 Oak Ave.
 Lake Crest Villa—A
 2601 Central St.
 Pioneer Place—AB
 2320 Pioneer Rd.
 Presbyterian Home—AB
 3200 Grant St.
- FAIRBURY (Livingston County)
 Fairview Haven, Inc.—AB
 605-609 N. Fourth
- FOREST PARK (Cook County)
 Altenheim (German Old Peoples Home)—AB
 7824 Madison St.
- FREEPORT (Stephenson County)
 Freeport Bensenville Home—A
 822 W. Stephenson St.
 Park View Home—A
 South Park Blvd.
 St. Joseph Home for the Aged—AB
 649 E. Jefferson St.
- GIRARD (Macoupin County)
 The Home—A
- GLENVIEW (Cook County)
 Maryhaven Village for Aged and Blind—AB
 1700 E. Lake Ave.
- GOLDEN (Adams County)
 Golden Good Shepherd Home, Inc.—AB
- GURNEE (Lake County)
 Independent Order of Vikings Home for
 Aged Members—AB
 Grand Ave.
- HIGHLAND (Madison County)
 Highland Home—A
 1600 Walnut St.
- HIGHLAND PARK (Lake County)
 Villa St. Cyril—AB
 111 St. Johns Ave
- HINSDALE (Cook County)
 King-Bruwaert House—AB
 6101 County Line Rd.
- HINSDALE (DuPage County)
 Godair Home—AB
 6259 S. Madison St.
- JACKSONVILLE (Morgan County)
 Illinois Christian Home, Inc.—AB
 873 Grove St.
- JOLIET (Will County)
 Our Lady of Angels Retirement Home—AB
 1201 Wyoming Ave.
 Salem Home for the Aged—AB
 1313 Rowell Ave.
- JUSTICE (Cook County)
 Rosary Hill Convalescent Home—AB
 9000 W. 81st St.
- KEWANEE (Henry County)
 St. Bernadette Manor—A
 Elliott St.
- KNOXVILLE (Knox County)
 Illinois P.E.O. Home—A
 415 E. Main St.
- LaGRANGE PARK (Cook County)
 Plymouth Place—AB
 315 N. LaGrange Rd.
- LAKE VILLA (Lake County)
 American Aid and Old Peoples Home
 Society—A
 Grand Ave.
- LAWRENCEVILLE (Lawrence County)
 The Methodist Home—AB
 1601 S. Sixteenth St.
- LEMONT (Cook County)
 Holy Family Villa—AB
 123rd St.
 Mother Theresa Home—AB
 1270 Main St.
- LIBERTYVILLE (Lake County)
 St. John's of Allendale—A
 59A and Milwaukee Rd.
- LINCOLN (Logan County)
 Deaconess Memorial Home Annex—A
 315 Eighth St.
- LYONS (Cook County)
 Illinois Colony Club Home for Aged—AB
 7515 Ogden Ave.
- MACOMB (McDonough County)
 Everly House—A
 811 S. Lafayette St.
- MACON (Macon County)
 Eastern Star Home at Macon—AB
- MATTOON (Coles County)
 Illinois I.O.O.F. Old Folk's Home—AB
 E. Lafayette St.
- MAYWOOD (Cook County)
 Maywood Baptist Home—AB
 316 Randolph St.
 Maywood Home for Soldiers Widows—A
 224 N. First Ave.

- MEADOWS (McLean County)
Meadows Mennonite Home—A
- MENDOTA (LaSalle County)
Mendota Lutheran Home—A
504 Sixth St.
- MORRISON (Whiteside County)
Resthaven Home of Whiteside County—A
Maple Ave.
- MT. CARROLL (Carroll County)
Caroline Mark Home—A
222 E. Lincoln St.
- MT. MORRIS (Ogle County)
Pinecrest Manor—AB
414 S. McKendrie Ave.
- NEW ATHENS (St. Clair County)
New Athens Home—AB
203 S. Johnson St.
- NILES (Cook County)
St. Andrew Home for the Aged—AB
7000 N. Newark Ave.
St. Benedict's Home for the Aged—AB
6930 W. Touhy Ave.
- NORMAL (McLean County)
Shamel Manor—A
509 N. Adelaide
- NORRIDGE (Cook County)
Central Baptist Home for the Aged—AB
7901 W. Lawrence Ave.
- NORTHLAKE (Cook County)
Villa Scalabrini—AB
Wolf Rd. and Palmer St.
- NORTH RIVERSIDE (Cook County)
Scottish Old Peoples Home—AB
28th St. and DesPlaines Rd.
- OTTAWA (LaSalle County)
Cora J. Pope Home—A
116 W. Prospect St.
Pleasant View Luther Home—AB
505 College Ave.
- PARK RIDGE (Cook County)
St. Matthew United Lutheran Home—AB
1601 N. Western Ave.
- PAXTON (Ford County)
Illinois Knight Templar Home for the
Aged Infirm—B
706 S. Washington St.
- PEORIA (Peoria County)
Apostolic Christian Home—A
711 N.E. Monroe Ave.
Christian Buehler Memorial Home—AB
3415 N. Sheridan Rd.
Guyer Memorial Home—A
201 W. Columbia Terr.
John C. Proctor Endowment Home—AB
1301 N.E. Glendale Ave.
St. Joseph's Home for the Aged—AB
2223 W. Heading Ave.
- PEOTONE (Will County)
Peotone Bensenville Home—A
Wood and West Sts.
- PONTIAC (Livingston County)
Evenglow Lodge—A
209 E. Washington St.
- Humiston Haven—AB
300 W. Lowell St.
- PRINCETON (Bureau County)
Adeline E. Prouty Home—A
508 Park Ave. East
- QUINCY (Adams County)
Anna Brown Home for the Aged—AB
1507 N. Fifth St.
Good Samaritan Home—AB
2130 Harrison St.
Methodist Sunset Home—AB
418 Washington St.
St. Vincent's Home—A
1340 N. Tenth St.
- ROCKFORD (Winnebago County)
Eastern Star Home of Rockford—AB
2400 S. Main St.
P. A. Peterson Home—AB
1301 Parkview Ave.
Winnebago Home for the Aged—AB
Box 76-A, Safford Rd.
- ROCK ISLAND (Rock Island County)
Cleaveland Home for the King's Daughters
of Illinois, Inc.—A
805 Nineteenth St.
Huber Memorial Home—A
1000—30th St.
- SPRINGFIELD (Sangamon County)
Carrie Post King's Daughters Home
for Women—A
541 Black Ave.
Illinois Presbyterian Home—A
W. Lawrence at Chatham Rd.
Mary Bryant Home for the Blind—B
1100 S. Fifth St.
St. Joseph's Home for the Aged—A
S. Sixth Street Rd.
- SULLIVAN (Moultrie County)
Illinois Masonic Home—AB
- TECHNY (Cook County)
St. Ann's Home and Infirmary—AB
Waukegan Rd.
- VIRDEN (Macoupin County)
Mothers' Memorial Baptist Home—AB
402 W. Loud St.
- WHEELING (Cook County)
Addolorata Villa—AB
Hwy. 83, McHenry Rd.
- WILMETTE (Cook County)
Baha'i Home—A
401 Greenleaf Ave.
Maryhaven, Inc.—AB
2228 Beechwood Ave.
- WOODSTOCK (McHenry County)
Sunset Manor, Inc.
920 Seminary Ave.
- ZION (Lake County)
Bethesda of the Christian Catholic Church—A
2516-22 Elisha Ave.

PRE-POSITIONED PACKAGED DISASTER HOSPITALS IN ILLINOIS (AS OF MAY 19, 1965)

ALTON (Madison County) Alton State Hospital	JOLIET (Will County) Barrett Hardware
ANNA (Union County) Anna State Hospital	KANKAKEE (Kankakee County) Kankakee County Court House
ASHKUM (Iroquois County) Lawson Contracting Co.	LINCOLN (Logan County) Lincoln State School
AURORA (Kane County)	City of Lincoln Warehouse
BARTONVILLE (Peoria County) Bartonville Civil Defense Center	MANTENO (Kankakee County) Manteno State Hospital
CAIRO (Alexander County) City of Cairo Warehouse	Our Lady's Academy
CARLINVILLE (Macoupin County) Business Bldg.	MATTOON (Coles County) Moody Manufacturing Co.
CENTRALIA (Marion County) Chapel Bldg.	METROPOLIS (Massac County) Power and Light Bldg.
CHAMPAIGN (Champaign County) Illinois Power Co.	MT. CARMEL (Wabash County) City Bldg.
CHARLESTON (Coles County) Eastern Illinois University Jefferson Junior High School	NORMAL (McLean County) Illinois Soldiers' and Sailors' Children's Hospital
CHICAGO HEIGHTS (Cook County) City Hall	OLNEY (Richland County) Richland County Court House
DANVILLE (Vermilion County) St. Elizabeth's Hospital	OQUAWKA (Henderson County) Old Opera House
DECATUR (Macon County) Decatur Municipal Airport	OTTAWA (LaSalle County) Libby Owens Ford Glass Plant
DIXON (Lee County) Dixon State School	PALATINE (Cook County) Police Station
DU QUOIN (Perry County) Illinois Central Depot	PANA (Christian County) Pana Township Building
EDWARDSVILLE (Madison County) LeClair Grade School	PARIS (Edgar County) Houston Bldg.
ELDORADO (Saline County) Lincoln Grade School	QUINCY (Adams County) Illinois Soldiers' and Sailors' Home
ELGIN (Kane County) Elgin State Hospital	ROCKFORD (Winnebago County) Whitehead Elementary School
ERIE (Whiteside County) Erie Community High School	RUSHVILLE (Schuyler County) Scripps Park Country Club
FLORA (Clay County) Old Light and Power Plant Bldg.	SAVANNA (Carroll County) Savanna Ordnance Depot
GALESBURG (Knox County) Galesburg State Research Hospital	SKOKIE (Cook County) G. D. Searle and Co.
Knox County Court House	STERLING (Whiteside County) City Hall
GARDNER (Grundy County) Garfield Township Building	ST. CHARLES (Kane County) Club House-Pottawatomie Park
HAVANA (Mason County) Chicago and Illinois Midland Depot	TUSCOLA (Douglas County) Douglas County Court House
HIGHLAND PARK (Cook County) Highland Park Water Plant	WATERLOO (Monroe County) Monroe County Nursing Home
JACKSONVILLE (Morgan County) Jacksonville State Hospital	WEST FRANKFORT (Franklin County) Franklin County Civil Defense Center
JERSEYVILLE (Jersey County) Jersey County Court House	WHEATON (DuPage County) DuPage County Convalescent Home

TRAINING PACKAGED DISASTER HOSPITALS IN ILLINOIS (AS OF MAY 19, 1965)

CARBONDALE (Jackson County)

Southern Illinois University

CHICAGO (Cook County)

Chicago State Hospital

DE KALB (DeKalb County)

Northern Illinois University

ELMHURST (DuPage County)

York Community High School

PEORIA (Peoria County)

Peoria County Civil Defense

ROCK ISLAND (Rock Island County)

Black Hawk State Park

SALEM (Marion County)

Salem Memorial Hospital

WAUKEGAN (Lake County)

Waukegan Storage Company

SWANSEA (St. Clair County)

St. Clair County Civil Defense

APPROVED SCHOOLS OF NURSING

Associate Degree Programs

A program in nursing leading to an associate degree; generally established in a community or junior college. The curriculum consists of arts and sciences at the junior college level and nursing theory—closely correlated with nursing practice in community hospitals and other facilities. Graduates are prepared to give bedside nursing care to patients in hospitals, nursing homes and similar situations. They are prepared to cooperate and share responsibility for their patients' welfare with other members of the nursing and health staff, and to be self-directive in learning from their experiences as practicing nurses.

Belleville Junior College

2600 W. Main, Belleville

Baccalaureate Degree Programs

A program which combines general education with nursing education, leading to the Bachelor of Science degree with a major in nursing. Its general and professional education are coordinated; literature, fine arts and other liberal education courses are shared with all college students; courses in communication skills and the biological, physical and behavioral sciences serve as the base upon which nursing courses are built. Nursing theory is closely coordinated with nursing practice, under the direction and supervision of the nursing faculty of the college or university, in a variety of hospitals and public health agencies.

Graduates of baccalaureate programs in nursing are prepared for beginning nursing positions in community health services and for advancement, without further formal education, to positions requiring beginning administrative skills such as head nursing.

Graduates also have foundations for continuing personal and professional development and for graduate study in nursing.

Brokaw Collegiate School of Nursing

Illinois Wesleyan University, Bloomington

Loyola University School of Nursing

820 N. Michigan Ave., Chicago

Northern Illinois University

School of Nursing, DeKalb

St. Xavier College, School of Nursing

103rd & Central Park, Chicago

Southern Illinois University

School of Nursing, Carbondale

University of Illinois, College of Nursing

808 S. Wood St., Chicago

Diploma Programs

A program leading to a diploma in nursing, which is under the auspices of a hospital or which is independently incorporated. The curriculum consists of theory and practice focused on instruction and related clinical experience in the nursing care of patients in hospitals. Graduates have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be responsible for the direction of other members of the nursing team.

Alexian Brothers Hospital

2331 N. Lakewood Ave., Chicago

Alton Memorial Hospital

Memorial Dr., Alton

Augustana Hospital

411 W. Dickens Ave., Chicago

Blessing Hospital

1005 Broadway St., Quincy

Burnham City Hospital

311 E. Stoughton St., Champaign

Chicago Wesley Memorial Hospital

250 E. Superior St., Chicago

Columbus Hospital

2520 Lake View Ave., Chicago

Cook County School of Nursing

1900 W. Polk St., Chicago

Copley Hospital

Lincoln & Weston Ave., Aurora

Decatur & Macon County Hospital

2300 N. Edward St., Decatur

Dixon Public Hospital

403 E. First St., Dixon

Evangelical Hospital

5421 S. Morgan St., Chicago

Evanston Hospital

2650 Ridge Ave., Evanston

Freeport Memorial Hospital

420 S. Harlem Ave., Freeport

Galesburg Cottage Hospital

674 N. Seminary St., Galesburg

Graham Hospital

210 W. Walnut St., Canton

Grant Hospital

551 W. Grant Pl., Chicago

Hinsdale Sanitarium and Hospital

120 N. Oak St., Hinsdale

Illinois Masonic Hospital
 836 Wellington Ave., Chicago
 Lake View Memorial Hospital
 812 N. Logan Ave., Danville
 Little Company of Mary Hospital
 2800 W. 95th St., Evergreen Park
 Lutheran General Hospital
 1775 Dempster St., Park Ridge
 Lutheran Hospital
 506 Fifth Ave., Moline
 Memorial Hospital of Springfield
 First & Miller Sts., Springfield
 Mennonite Hospital
 804 N. East St., Bloomington
 Mercy Hospital
 1407 W. Park St., Urbana
 Methodist Hospital
 221 N. Glen Oak Ave., Peoria
 Michael Reese Hospital
 29th St. and Ellis Ave., Chicago
 Moline Public Hospital
 622 Fifth Ave., Moline
 Mt. Sinai Hospital
 2730 W. 15th Pl., Chicago
 Oak Park Hospital
 525 Wisconsin Ave., Oak Park
 Passavant Memorial Hospital
 303 E. Superior St., Chicago
 Passavant Memorial Hospital
 W. Walnut St., Rt. 104, Jacksonville
 Presbyterian-St. Luke's Hospital
 1753 W. Congress Pkwy., Chicago
 Provident Hospital
 426 E. 51st St., Chicago
 Ravenswood Hospital
 1931 W. Wilson Ave., Chicago
 Rockford Memorial Hospital
 2400 N. Rockton Ave., Rockford
 Roseland Community Hospital
 45 W. 111th St., Chicago
 St. Anne's Hospital
 4900 Thomas St., Chicago
 St. Anthony de Padua Hospital
 19th St. and Marshall Ave., Chicago
 St. Anthony's Hospital
 1411 E. State St., Rockford
 St. Anthony's Hospital
 767—30th St., Rock Island
 St. Bernard's Hospital
 6337 S. Harvard Ave., Chicago
 St. Charles Hospital
 400 New York St., Aurora
 St. Elizabeth Hospital
 1433 N. Claremont Ave., Chicago
 St. Elizabeth Hospital
 602 Green St., Danville
 St. Francis Hospital
 319 Ridge Ave., Evanston
 St. Francis Hospital
 211 Greenleaf St., Peoria
 St. John's Hospital
 821 E. Mason St., Springfield
 St. Joseph's Hospital
 915 E. Fifth St., Alton

St. Joseph's Hospital
 333 N. Madison St., Joliet
 St. Mary's Hospital
 145 S. Fourth Ave., Kankakee
 St. Mary of Nazareth Hospital
 1127 N. Oakley St., Chicago
 St. Therese Hospital
 W. Washington St., Waukegan
 Silver Cross Hospital
 Eagle and Walnut Sts., Joliet
 South Chicago Community Hospital
 2320 E. 92nd Pl., Chicago
 Swedish-American Hospital
 1316 Charles St., Rockford
 Swedish Covenant Hospital
 5145 N. California Ave., Chicago
 Walther Memorial Hospital
 1116 N. Kedzie Ave., Chicago
 West Suburban Hospital
 518 N. Austin Blvd., Oak Park

Practical Nursing Programs

A program leading to a certificate or diploma in practical nursing, organized and operated under public vocational education, hospitals, or other community agencies.

This type of program, usually one year in length, is complete and satisfactory for its own purpose, preparing exclusively for practical nursing.

The curriculum is planned to include nursing theory and practice which is consistent with a short-term program. Courses include such subjects as nursing theory and practice, body structure and function, personal hygiene and community health, nutrition and home management, vocational relationships.

Graduates of programs in practical nursing are prepared for two roles: (1) under the supervision of a registered nurse or physician, they give nursing care to patients in situations relatively free of scientific complexity; (2) in a close working relationship, they assist in giving nursing care to patients in more complex situations.

F. W. Olin Vocational School of Practical Nursing
 2200 College Ave., Alton
 McAuley Mercy School of Practical Nursing
 421 N. Lake St., Aurora
 Bloomington School of Practical Nursing
 Public School District 87
 709 S. Clinton St., Bloomington
 Vocational Technical Institute School of
 Practical Nursing
 Southern Illinois University
 Southern Acres Campus, Carbondale
 School of Practical Nursing
 Champaign Community School Unit
 District No. 4
 610 W. University Ave., Champaign
 Practical Nursing Center
 Chicago Public Schools
 1820 W. Grenshaw St., Chicago
 St. Francis Xavier Cabrini School of
 Practical Nursing
 811 S. Lytle St., Chicago

Danville Junior College School of Practical Nursing
Washington School
305 W. Madison St., Danville

Decatur School of Practical Nursing
Gastman School Bldg.
210 W. North St., Decatur

Dixon State School of Practical Nursing
2600 N. Brinton Ave., Dixon

School of Practical Nursing
East St. Louis District 189
4901 State St., East St. Louis

Galesburg School of Practical Nursing
Community Unit School District 205
650 Locust St., Galesburg

Southeastern Illinois College
School of Practical Nursing
Harrisburg

Hinsdale Sanitarium and Hospital
School of Practical Nursing
120 N. Oak St., Hinsdale

Kankakee Senior High School
School of Practical Nursing
240 Warren Ave., Kankakee

St. Mary's School of Practical Nursing
1015 O'Connor St., LaSalle

Mattoon School of Practical Nursing
Community Unit District 2
112 N. 22nd St., Mattoon

Proviso Township School of Practical Nursing
Proviso East High School, Maywood

Mt. Vernon School of Practical Nursing
7th and Casey Sts., Mt. Vernon

Oak Forest Hospital School of Practical Nursing
15900 S. Cicero Ave., Oak Forest

Peoria School of Practical Nursing
509 W. High St., Peoria

Quincy School of Practical Nursing
Quincy Senior High School
Maine St. at 13th, Quincy

Rock Island County School of Practical Nursing
2122—25th Ave., Rock Island

Rockford School of Practical Nursing
Rockford Public Schools
201 S. Madison St., Rockford

Niles Township Community High School
School of Practical Nursing
Gross Point Rd. & Oakton St., Skokie

School of Practical Nursing
Springfield Public Schools
101 E. Laurel St., Springfield

Sterling Township High School
Practical Nursing Program
1214 Fifth Ave., Sterling

Practical Nursing Program
Waukegan Township High School
1011 W. Washington St., Waukegan

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School
710 S. Wolcott Ave.
Chicago, Ill. 60612
Daniel S. Kushner, M.D., Dean
CA 6-4100

Northwestern University Medical School
303 E. Chicago Ave.
Chicago, Ill. 60611

Richard H. Young, M.D., Dean
649-8649

Stritch School of Medicine—Loyola University
Hines, Ill.

MU 1-5330
921-2610

John F. Sheehan, M.D., Dean
706 S. Wolcott Ave.
Chicago, Ill. 60612
SE 3-8040

University of Chicago School of Medicine
950 E. 59th St.

Chicago, Ill. 60637
H. Stanley Bennett, M.D., Dean
MU 4-6100

University of Illinois College of Medicine
1853 W. Polk St.

Chicago, Ill. 60612
Granville A. Bennett, M.D., Dean
663-7000

APPROVED SCHOOLS FOR MEDICAL RECORD LIBRARIANS

CHICAGO—Grant Hospital

DANVILLE—St. Elizabeth Hospital

APPROVED COURSE IN OCCUPATIONAL THERAPY

CHICAGO—University of Illinois College of Medicine

APPROVED SCHOOL OF PHYSICAL THERAPY

CHICAGO—Northwestern University Medical School

APPROVED SCHOOLS OF X-RAY TECHNOLOGY

ARLINGTON HTS.—Northwest Community Hospital

AURORA—Copley Memorial Hospital
St. Charles Hospital
St. Joseph Mercy Hospital

BLUE ISLAND—St. Francis Hospital

CHICAGO—Cook County Graduate School of Medicine

Edgewater Hospital
Englewood Hospital
Evangelical Hospital
Franklin Boulevard Community Hospital

Grant Hospital
Illinois Masonic Hospital
Louis A. Weiss Memorial Hospital
Lutheran Deaconess Hospital
Mary Thompson Hospital

Michael Reese Hospital
 Mt. Sinai Hospital
 Norwegian American Hospital
 Presbyterian-St. Luke's Hospital
 Provident Hospital
 Ravenswood Hospital
 St. Anne's Hospital
 St. Bernard's Hospital
 St. Elizabeth's Hospital
 St. Joseph Hospital
 St. Mary of Nazareth Hospital
 South Chicago Community Hospital
 Woodlawn Hospital

DANVILLE—Lake View Memorial Hospital
 DECATUR—Decatur and Macon County Hospital
 DIXON—Dixon Public Hospital
 EAST ST. LOUIS—Centreville Township Hospital
 ELMHURST—Memorial Hospital of DuPage County
 EVANSTON—St. Francis Hospital
 EVERGREEN PARK—Little Company of Mary Hospital
 HARVEY—Ingalls Memorial Hospital
 HINSDALE—Hinsdale Sanitarium and Hospital
 JOLIET—Silver Cross Hospital
 KANKAKEE—St. Mary's Hospital
 KEWANEE—Kewanee Public Hospital
 MOLINE—Moline Public Hospital
 OAK PARK—West Suburban Hospital
 PARK RIDGE—Lutheran General Hospital
 PEORIA—Methodist Hospital of Central Illinois
 St. Francis Hospital
 QUINCY—Blessing Hospital
 ROCKFORD—Rockford Memorial Hospital
 St. Anthony Hospital
 Swedish-American Hospital
 ROCK ISLAND—St. Anthony's Hospital
 SPRINGFIELD—Memorial Hospital
 St. John's Hospital
 URBANA—Carle Memorial Hospital

APPROVED SCHOOLS OF MEDICAL TECHNOLOGY

AURORA—Copley Memorial Hospital
 BLOOMINGTON—St. Joseph's Hospital
 BLUE ISLAND—St. Francis Hospital
 CHAMPAIGN—Burnham City Hospital
 CHICAGO—Alexian Brothers Hospital, Augustana Hospital, Chicago Wesley Memorial Hospital, Edgewater Hospital, Evangelical Hospital of Chicago, Grant Hospital of Chicago, Holy Cross Hospital, Hospital of St. Anthony de Padua, Illinois Masonic Hospital, Michael Reese Hospital, Mount Sinai Hospital, Northwestern University

Medical School, (Passavant Memorial Hospital), Presbyterian-St. Luke's Hospital, St. Anne's Hospital, St. Bernard's Hospital, St. Joseph Hospital, St. Mary of Nazareth Hospital and Veterans Administration Research Hospital

CHICAGO HEIGHTS—St. James Hospital
 DANVILLE—Lake View Memorial Hospital
 DECATUR—Decatur and Macon County Hospital and St. Mary's Hospital
 EVANSTON—Evanston Hospital and St. Francis Hospital
 EVERGREEN PARK—Little Company of Mary Hospital
 FREEPORT—Freeport Memorial Hospital
 HARVEY—Ingalls Memorial Hospital
 HINSDALE—Hinsdale Sanitarium and Hospital
 JOLIET—Silver Cross Hospital
 MOLINE—Moline Public Hospital
 OAK PARK—West Suburban Hospital
 PEORIA—Methodist Hospital, Proctor Community Hospital and St. Francis Hospital
 QUINCY—Blessing Hospital and St. Mary's Hospital
 ROCKFORD—Rockford Memorial Hospital, St. Anthony Hospital and Swedish-American Hospital
 ROCK ISLAND—St. Anthony Hospital
 SPRINGFIELD—Memorial Hospital and St. John's Hospital
 URBANA—Carle Foundation
 WAUKEGAN—St. Therese's Hospital

APPROVED SCHOOLS OF CYTOTECHNOLOGY

CHICAGO—Michael Reese Hospital and Medical Center
 University of Chicago
 Hospitals and Clinics

APPROVED SCHOOLS OF INHALATION THERAPY

CHICAGO—Cook County Hospital, Edgewater Hospital, University of Chicago Hospitals

SCHOOLS FOR TRAINING CERTIFIED LABORATORY ASSISTANTS

ALTON—Alton Memorial Hospital
 CHICAGO—Swedish Covenant Hospital
 ELGIN—Sherman Hospital
 EVERGREEN PARK—Little Company of Mary Hospital

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION

The Illinois Medical Assistants Association is just what the name implies—an Association of Medical Assistants throughout the State of Illinois who have become an educational organization with objectives as follows: (a) To bring into one association all medical assistant organizations of the State of Illinois; (b) to provide an organization for those residing in Illinois counties where no medical assistants societies are organized; (c) to assist the physicians in improving medical public relations; (d) to maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (e) to meet from time to time to secure interchange of ideas.

The medical assistant associations are educational groups—not social. *We are not a union and any attempt to promote the unionization of this society or its members automatically forfeits the membership of the person or persons making such an attempt.*

For the first time the qualified medical assistant has been given an opportunity to pass a special board examination and thus become a "Certified Medical Assistant." This will affect directly or

indirectly every physician's office. Of note is the fact that you do not have to belong to the Association to take this examination. For further information as to qualifications necessary to take the examination write to American Association of Medical Assistants, 510 North Dearborn Street, Chicago 10, Illinois.

Local programs in the component societies of IMAA are geared to the needs of that particular area. Obviously the strictly specialist areas would have entirely different problems and educational needs than the area of the general practitioner where the office is staffed by one or two medical assistants. Hence the educational programs in your area would be decided by your own Medical Assistants and supervised by the doctors in your own county society.

We need you, Doctor, to encourage your medical assistants to join our association. But also you could help us by assisting us in selecting the proper educational programs which in the long run would be of most benefit to you. That is our whole purpose, to become better medical assistants so we can help you to help your patients.

ILLINOIS ASSOCIATION OF THE PROFESSIONS

The Illinois Association of the Professions is a nonprofit corporation, incorporated under the laws of Illinois on Feb. 6, 1964. Several other states such as Michigan, New York and North Carolina have already organized associations of professions with the same basic structure and purpose and an American Association of the Professions has been incorporated.

The IAP was created to provide the organizational machinery whereby the combined strength and counsel of all professions can be utilized for the advancement of professional ideals and the promotion of professional welfare. This should strengthen the traditional rights, privileges and responsibilities of each profession. At the same time, it should also provide more effectively to the people adequate professional services based on skill and integrity.

The close relationships between members of the professions place them in a better position to be "molders of public policy." The IAP will devise ways and means of better utilizing the professional knowledge and skills of its members for the benefit of society and attempt to create the kind of relations between the professions which will most effectively accomplish this objective.

IAP is *not* a political organization. It is non-partisan. But it serves its members as one practical

medium of communication between the professions and legislative bodies.

IAP supplements efforts, programs and services of the individual state professional societies. The professional societies must function for the profession each represents.

The IAP benefits the individual member by helping him protect and perpetuate the individual privileges and responsibilities of the professional person. It serves as a medium of communication between the professions, devoting its activities to professional relations, public relations, legislation, education, and business services.

Seven state professional societies founded the IAP.

Architects Association of Illinois.

Illinois State Dental Society.

Illinois Society of Professional Engineers.

Illinois State Medical Society.

Illinois Pharmaceutical Association.

Illinois State Veterinary Medical Association.

Illinois State Bar Association.

Admission of other professional societies to membership is provided for in the IAP bylaws.

The IAP is governed by a board of directors. On that board *recognition*, rather than *control*, is

accorded those professions having larger numbers of individual members. IAP bylaws provide that the board of directors of each state organization shall designate two of its members, who are also members of IAP, to serve as directors. In addition to those thus provided, Directors are also elected from the general membership at the IAP Annual Meeting. ISMS delegates are Dr. George B. Callahan and Dr. Edward A. Piszczek, alternate.

Each IAP member automatically receives a subscription to MONITOR, a quarterly publication of the Association of the Professions. Special reports and studies are disseminated directly to the individual member.

Annual dues for an individual member in IAP is \$10. Annual dues for a professional society organization is \$100. Applications and checks are accepted by the executive secretary of state professional associations for processing.

IAP is a "horizontal" type of organization established to answer some of the professional's problems just as other segments of society are organized. Labor, for example, has the AFL-CIO—cutting across all trades on an industry-wide basis. State and national Chambers of Commerce were created for business and the American Federation of Farm Bureaus, one of the greatest forces in our nation, is the voice of farming.

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE (IMPAC)

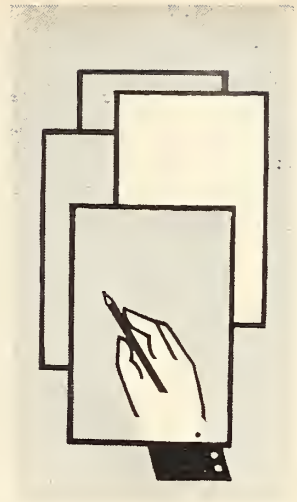
The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress. It

cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local IMPAC committees, formed in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, 360 N. Michigan Ave., Chicago 60601.



MEDICAL-LEGAL INFORMATION

Legal Services of ISMS

The Illinois State Medical Society retains a general counsel and occasionally uses the services of special counsel in implementing its various programs. Legal advice is given to the state society and its components as organizations, but is not available to individual members.

The legal department of the Society can answer specific questions propounded by officers of county medical societies in Illinois, which are part of and make up the state society, if the questions are of interest to the membership as a whole.

Although the Society and its counsel cannot provide personal advice to ISMS members, it is to every physician's advantage to acquaint himself with as much general medical-legal knowledge as possible. The following section, therefore, is devoted to this kind of information.

HOW TO SET YOUR AFFAIRS IN ORDER

A physician's death, expected or not, often creates burdensome tasks for survivors. Natural grief is complicated by the necessity for rapid decisions and hurried searches for required information. Significant papers may be so well put away that prolonged seeking in various places may be required, with added pain for the bereaved.

It is therefore suggested that the physician, during his lifetime, ease the situation by compiling in one place needed information about the location of important records and papers. In addition, the Illinois State Medical Society urges each member to have a will prepared by a competent attorney and to have the said will re-evaluated by an attorney whenever there is any material change in any conditions.

The executor named in the will can handle the doctor's estate most efficiently if he has access to specific information.

The physician should, of course, leave information about insurance, real estate, and bank accounts just as everyone else does, but he has additional responsibilities peculiar to his profession. He should leave instructions for:

1. Temporary coverage of his practice. Some arrangement with a colleague should be made immediately for hospitalized patients and others should be notified of the doctor's death.

2. Patient records, which should be carefully preserved for a minimum of 10 years and for 25 years, if possible. Contents of the records should be turned over to another physician upon written request.

3. Return of unused narcotics to the Treasury Department, the narcotics tax stamp and order book to the Internal Revenue Service, and retention of the narcotics ledger for two years.

4. Disposal of his practice. If it is to be sold, rapid action is advised as value is lost quickly. Equipment is best disposed of with the sale of the practice.

5. Benefits that may be due survivors from unused insurance premiums, Blue Cross-Blue Shield, Veterans Administration, or Social Security.

As soon as practical after death, the attorney who will handle the estate should be contacted and his advice followed thereafter.

LEGAL LIABILITY OF PHYSICIANS

The legal liability of physicians is a question on which much has been written. It has also been the topic of discussion at many meetings of medical and medical-legal groups. However, because of the grave nature of the problem, the Illinois State Medical Society's legal counsel believes that the subject cannot be overemphasized.

Statistics prove that the number of malpractice and general liability suits against physicians is on the increase. This does not mean that physicians are becoming less skillful or more careless in their diagnosis and treatment; it probably means that

physicians are being affected by the tremendous growth there has been recently in all types of personal injury litigation.

More people than ever before are receiving medical attention and more are starting lawsuits against physicians when recovery is less than complete.

Liability Insurance

For this reason, it is essential that every physician carry liability insurance to protect him against all possible claims. The physician should be aware, however, that there are some inadequate policies on the market today and an attorney should be consulted before contracting for insurance that may not cover the doctor's particular circumstance. Additional coverage insofar as limits are concerned is relatively inexpensive and should be carried in sufficient amount to cover all possibilities.

A physician today is a "sitting duck" for a lawsuit even though he may in no way be guilty of negligence. And lawsuits to defend, no matter how meritorious, require the expenditure of time and money.

Legal implications in this field are wide, but basically the physician is liable for his own negligent acts and the negligent acts of all his employees. In the case of a partnership, he is also liable for the negligent acts of his partners.

While the right kind of insurance in sufficient amount will protect the physician financially, steps should be taken by all doctors to help minimize the filing of lawsuits of this kind and to work for reduction in the number of guilty verdicts being obtained.

The American Medical Association has prepared, and has available for distribution, several interesting pamphlets and papers on this subject. The pamphlet entitled, "Professional Liability and the Physician," reprinted from the February 1963 issue of the Journal of the American Medical Association, contains this statement:

Physician's Responsibility

"In the final analysis, the physician himself must share the responsibility for the continuing existence of the unpleasant professional liability situation. Many physicians have been satisfied to pay their professional liability insurance premiums and thereafter to sit back complacently, doing nothing until they become a target. Every physician must be brought to realize that this money payment is only part of his insurance program; a much more important part is his contribution of time, study, and attention to put into effect all possible measures to safeguard the patient, himself, and his colleagues. Professional liability is in no sense merely an insurance problem—it is a medical problem and must be combatted by members of the medical profession."

The AMA pamphlet goes on to say that "prevention is the best possible defense against claims and suits" and lists these 21 prevention "commandments":

1. The physician must care for every patient with

scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. The physician must avoid making any statement which constitutes, or might be construed as constituting an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure an "informed" consent (preferably in writing) for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

12. The physician should limit his practice to those fields which are well within his qualifications.

13. The physician must frequently check the condition of his equipment and make use of every available safety installation.

14. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

15. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

16. The physician should not sterilize a patient solely for the patient's convenience except after a reasonably complete explanation of the procedure and its risks and possible complications and after obtaining a signed consent from the patient and from the patient's spouse if the patient is married. Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the patient and preferably with the informed

consent of the patient's spouse, if the patient is married.

17. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

18. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

19. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

20. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes, and, in addition, should ascertain the customary dosage or usage in his area.

21. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

Physician and Hospital Liens

Paragraph 101.1 of Chapter 97, Illinois Revised Statutes 1963, provides that every licensed physician practicing in the State of Illinois who renders service to an injured person, except services rendered under the provisions of the Workmen's Compensation Act, shall have a lien upon all claims and causes of action for the amount of his reasonable charges up to one-third of the sum recovered by the injured person. In order to effectuate this lien, notice in writing must be given to the injured person and also to the person or persons against whom such claim or right of action exists.

Under paragraph 97 of Chapter 82, Illinois Revised Statutes 1963, not-for-profit hospitals and those hospitals maintained by a county shall have a lien on all claims or causes of action for the amount of reasonable charges at ward rates up to one-third of the amount recovered. Again, in order to perfect the lien, it must be filed in the same manner as the physician's lien described above.

While the language is substantially the same under both liens, they are entirely separate enactments, neither is subservient to the other and, therefore, both the hospitals and the physicians can recover up to one-third of the amount received by the patient.

Admissibility in Evidence of Deliberations of Tissue Committees

In 1963 the Illinois legislature passed an act in which one of the purposes was to prevent the admissibility in evidence and making public the deliberations and findings of tissue committees. The act is set out at paragraphs 101-105 of Chapter 51, Illinois Revised Statutes 1963, and is as follows:

"101. All information, interviews, reports, statements, memoranda or other data of the Illinois Department of Public Health, Illinois State Medical Society, allied medical societies, or in-hospital staff

committees of accredited hospitals, but not the original medical records pertaining to the patient, used in the course of medical study of the purpose of reducing morbidity or mortality shall be strictly confidential and shall be used only for medical research.

102. Such information, records, reports, statements, notes, memoranda, or other data, shall not be admissible as evidence in any action of any kind in any court or before any tribunal, board, agency or person.

103. The furnishing of such information in the course of a research project to the Illinois Department of Public Health, Illinois State Medical Society, allied medical societies, or to in-hospital staff committees or their authorized representatives, shall not subject any person, hospital, sanitarium, nursing or rest home or any such agency to any action for damages or other relief.

104. No patient, patient's relatives, or patient's friends named in any medical study, shall be interviewed for the purpose of such study, unless consent of the attending physician and surgeon is first obtained.

105. The disclosure of any information, records, reports, statements, notes, memoranda or other data obtained in any such medical study except that necessary for the purpose of the specific study is unlawful, and any person convicted of violating any of the provisions of this Act is guilty of a misdemeanor."

While there have been no decisions under the act quoted by any of the Illinois appellate courts or the Supreme Court, it would appear that a tissue committee would come within the meaning of "in-hospital staff committees of accredited hospitals," and, therefore, would be inadmissible in evidence and considered private and confidential. Unfortunately, the act does not define accredited hospitals, but this would probably mean either licensed hospitals or those accredited by the medical professions. (There are only 10 licensed hospitals in Illinois which have not been accredited by the medical professions.)

In addition to the above statute, the fact that tissue committees are not required by Illinois law, but are established through the voluntary co-operation of the hospitals and the medical profession for the betterment of medicine through research of prior cases, would be a powerful argument against admissibility.

Another legal argument against the introduction in evidence of such records would be the fact that the results would be the deliberations of a committee and there would be no way to cross-examine a committee, which would mean that a fundamental right was being lost by one or more of the litigants in the case.

As stated above, there are no decisions in Illinois which can be relied upon, but it is the opinion of the ISMS general counsel that such records cannot legally be used in any legal action.

It should be pointed out that in most instances subpoenas and subpoenas duces tecum (produce the records) are issued by the clerk of the court on application of one of the parties litigants and no determination is made as to the admissibility of the testimony or records until the witnesses and records are produced in court. It is suggested that if a subpoena or court order is ever received involving the records and deliberations of the tissue committee, your attorney be immediately contacted in order to file appropriate motions to suppress the production of the records. If the trial court should hold that such records are admissible, it is then suggested that an appeal be made to the Supreme Court of Illinois on this question, for if such records are produced, it could conceivably have the result of diminishing the efficiency or the ultimate abandonment of such committees, with the result that research and advancement in the art of medicine would be retarded.

Consent by Minors to Medical Treatment and Operations

The general law in Illinois is that a minor cannot give legal consent or waive any rights which he has under the law. In the year 1961, the Illinois legislature made an exception to this rule by specifically providing that consent to the performance of medical or surgical treatment by a licensed physician could be executed by a married person who is a minor or a pregnant woman who is a minor and shall not be voidable because of such minority. This act further provides that any parent who is a minor may consent to the performance upon his or her child of medical or surgical procedures by a licensed physician and that the consent shall not be voidable because of such minority.

The act referred to above is set out at paragraphs 18.1 and 18.2 of Chapter 91, Illinois Revised Statutes 1963.

Employment Contract Between Physician and Patient

The relationship between a physician and a patient is one of contractual relationship and, therefore, a physician is under no legal requirement to accept anyone as a patient unless he so desires. This rule is true in the case of an emergency even though no other physician is available.

Legally, a physician has the right to refuse treatment in the case of an accident or other emergency and could not in any way be held liable for refusing to administer aid. (This is strictly the legal answer and does not involve the moral or ethical question.) The rendering of such services as may be necessary in the case of an emergency does not of itself give rise to the relationship of physician and patient and the physician is under no obligation to continue treatment beyond the emergency.

The physician in rendering emergency treatment, however, must use the same degree of skill and care, as required in other cases, taking into consideration conditions at the scene of the accident.

Continuation of Treatment

A physician or surgeon, on undertaking an operation or treatment, is under the duty, in the absence of an agreement limiting the service, of continuing his attendance, after the operation or first treatments, as long as the case requires attention; and a surgeon, in his treatment subsequent to an operation, is required to exercise reasonable and ordinary skill and care.

The failure to give needed continued care under an obligation to do so constitutes negligence or malpractice. The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship of physician and patient, by mutual consent of the parties, by the discharge of the physician by the patient, or by the physician's withdrawing from the case after giving the patient reasonable notice so as to enable him to secure other medical attendance.

A physician has the legal right to withdraw from a case if the patient breaks the contract by failure to follow the medical advice or treatment and direction of the physician, but the relationship cannot be terminated until the physician has advised the patient of his withdrawal from the case and has allowed the patient a reasonable length of time to procure another doctor.

Written Notice

What is reasonable notice to the patient depends upon the circumstances of each case. Factors which must be taken into consideration are the condition of the patient, the size of the community, and the availability of other physicians. In order to be completely safe, prior to withdrawal from the case, the physician should advise the patient in writing of his intent to withdraw, his reasons therefor, and the fact that he will make available the patient's case history and information regarding diagnosis and treatment to the new physician when selected by the patient. Should the patient return to the original physician stating that he has been unable to procure other medical aid, treatment should not be refused until a replacement has been obtained.

A physician has the right to leave his practice temporarily if he makes provisions for the attendance of a competent physician during his absence. This notice, which again preferably should be in writing, should be in sufficient time so that the patients can obtain replacements of their own choice if they do not desire to consult the physician temporarily handling the practice of the absent physician.

GOOD SAMARITAN BILL

The 1965 Legislature passed and the Governor signed Senate Bill 395, the so-called "Good Samaritan Bill." This bill provides that any physician who, in good faith, provides emergency care without a fee at the scene of a motor vehicle accident or in case of nuclear attack shall not as a result of his acts or omissions, except in the case of

gross willful or wanton negligence, be liable for damages.

The physician in rendering emergency treatment other than that necessitated by motor vehicle accidents or nuclear explosions must use the same degree of skill and care as required in other cases, taking into consideration conditions at the scene of the accident.

CONSUMER FRAUD ACT

This act is designed to protect the consumer. In part it reads,—“The act, use or employment by any person of any deception, fraud, false pretense, false promise, misrepresentation, or the concealment, suppression, or omission of any material fact with intent that others rely upon such concealment, suppression or omission, in connection with the sale or advertisement of any merchandise, whether or not any person has in fact been misled, deceived or damaged thereby, is declared to be an unlawful practice.” The term merchandise includes any objects, wares, goods, commodities, intangibles, real estate, or services.

COMMITMENT OF PATIENTS TO MENTAL HOSPITALS

The State of Illinois has adopted an entirely new Mental Health Act which went into effect July 1, 1964, which Act is set out under Chapter 91½, Illinois Revised Statutes 1963.

Under the provisions of this Act, there are six ways in which an individual may be admitted to a mental hospital:

1. Informal admission
2. Voluntary application for admission
3. Admission on certificate of one physician
4. Admission on certificate of two physicians
5. Hospitalization upon court order
6. Emergency admission, detention

Informal admission:

Anyone desiring admission to a mental hospital, other than a licensed private hospital, may be admitted without making formal application if, after examination, the superintendent of such hospital feels such person is in need of care and treatment. Any such patient shall be free to leave at any time after admission.

Voluntary application for admission:

Any person who is in need of mental treatment or is alleged to be in need of mental treatment may be admitted to a mental hospital if, in the judgment of the superintendent, such person is a proper subject for voluntary admission after a verified application has been filed, with the application being presented by the person himself or his attorney, or if a minor, by his parent or guardian. Upon this type of admission, the patient has the right to leave the hospital 15 days after having given notice in writing of his desire to leave and upon admission the patient shall be advised both orally and in writing of this right of release.

Admission on certificate of one physician:

The superintendent of a mental hospital may receive and detain as a patient any person alleged to be in need of mental treatment who does not object thereto upon the application signed by a relative of the patient or peace or health officer or an officer of any charitable or welfare institution or by a friend of the patient together with the certificate of one examining physician executed within 10 days prior to such admission. Prior to admission the superintendent of the mental hospital shall cause the patient to be again examined in order to confirm the need for hospitalization. If the hospital determines within 15 days after admission that the patient should be detained for further care and treatment and the patient does not agree to remain in the hospital as a voluntary patient, the certificate of another examining physician supporting the application is required.

Admission on certificate of two physicians:

The same general procedure is followed here as in the case of admission on certificate of one physician, except that the consent of the patient is not required, but within five days after his admission he shall consult at the hospital with a magistrate or other judicial officer, at which time he shall be advised of his right to hearing, at which hearing he may be represented by counsel and present evidence.

Hospitalization upon court order:

Whenever any person shall be, or supposed to be, in need of mental treatment, any reputable citizen of this state may file in the Circuit Court the verified petition alleging that the individual is in need of mental treatment and that he be admitted to, and confined to, a hospital for the mentally ill. Upon the filing of the petition the Court shall have power to make necessary temporary orders of restraint and a hearing shall be had after an examination has been made by a physician or psychologist appointed by the court. At the hearing the patient may be represented by counsel and has the right to a trial by a jury of six. When the patient demands a jury, one of the six members shall be a physician or a psychologist.

Emergency admission, detention:

Whenever a petition is filed in the Circuit Court by a reputable citizen alleging that the condition of an individual is such that immediate restraint is necessary, which petition is accompanied by a certificate of a physician, the individual may be confined in a mental hospital for a period not exceeding 15 days.

This new Mental Health Act appears to contain adequate provisions for the confinement of mental cases but also provides sufficient safeguards so that an individual cannot be wrongfully restrained for an undue period of time.

The State's Attorney of each county is charged with the responsibility of the enforcement and

operation of this Act and this is the office which should be contacted by the physician when dealing with mental patients.

INTERNAL REVENUE CODE

It should be evident to the busy physician that it is just as unwise for him to be his own tax consultant as it is for every man to be his own doctor. The physician is well aware that in seeking to keep abreast of all of the ramifications and developments of modern medicine, he has a burden that is becoming increasingly difficult to sustain and that he has very little time to devote to subjects as complex as taxation, which is rightfully the province of his accountant and lawyer.

Taxation in the United States is complex and many tax matters have no particular application to the medical profession as such. However, the doctor as a citizen should be aware that he is greatly affected by a subject so varied and so complicated that the statutes themselves require some 1,500 pages to be set forth. And he should know that sections 1(a) through 8023(b) are printed in a size of type that should be of some benefit in fees to practitioners who concern themselves with the human eye. Surely the point that physicians are well advised to place their problems with accounting and legal advisors is further exemplified by such facts as the following:

Regulations implementing the Internal Revenue Act require some 9,700 pages for them to be spelled out and that, in order to designate the different regulations, the government needs to entitle the regulations as Regulation Section 1.0-1 through Regulation Section 301.770-11.

Just as the patient would be so much better served if he saw his doctor regularly before difficulties become advanced, so the physician's interests would be better served if he would seek advice on income and estate tax problems before the fact, rather than after problems have arisen.

PROCEDURES AND REPORTS IN CONTROL OF NARCOTIC DRUGS

Physicians are subject to control by both the state of Illinois and the federal government in relation to narcotic drugs. The numerous provisions of the federal regulations are set forth in a fairly lengthy pamphlet entitled, "Regulations No. 5 Relating to the Importation, Manufacture, Production, Sale, etc., of Opium, Coca Leaves, Isonipeaine or Opiates," which was reprinted April 1, 1957, and is available at a cost of 45 cents through the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. This is published by the Bureau of Narcotics of the U. S. Treasury Department.

The state of Illinois' "Uniform Narcotic Drug Act" has been in effect since Jan. 1, 1958. It is found in paragraphs 22-1 through 22-49, inclusive, Chapter 38 of Illinois Revised Statutes, 1963. The Division of Narcotic Control's current rules and regulations to implement the Act have been in effect

since Apr. 1, 1960. They cover such matters as prescriptions and official forms therefor, emergencies excusing use of other than official prescription forms, reporting of loss or theft of such prescription blanks, records to be kept by the physician, dispensing of hypodermic syringes and needles, prescribing procedures in hospitals, and other subjects related to narcotic drugs. The Act and the rules and regulations are available at no cost through the Division of Narcotic Control, 623 E. Adams St., Springfield.

Further, the state of Illinois has had in effect since Jan. 1, 1960, a "Uniform Drug, Device and Cosmetic Act." Its rules and regulations control such things as the keeping of adequate records, for a period of two years, of all purchases and dispositions of dangerous drugs as such drugs are defined by the Act. A publication containing the Act and the pursuant rules and regulations is also available through the Division of Narcotic Control in Springfield.

All physicians are urged to have in their possession copies of both the state and federal narcotics control acts and the rules and regulations implementing them. As these laws and regulations are changed from time to time, every effort should be made to have the current rules handy.

PROCEDURES AND REPORTS AS TO COMMUNICABLE DISEASES

In order to be conversant with the presently governing rules and regulations as to the control of communicable diseases and the physician's duties as to reports and procedures in relation to these afflictions, it is suggested that the physician apply to the Department of Public Health of the State of Illinois at Room 500, State Office Building, Springfield, for the publication entitled, "Rules and Regulations for the Control of Communicable Diseases," which was revised July 1, 1959.

HOW TO WILL YOUR BODY OR ANY PORTION THEREOF TO SCIENCE

The law in the State of Illinois as to the right of an individual to leave his body or particular parts thereof to science by will or agreement is not at all clear. While there are instances of medical science receiving dead bodies or parts thereof under provisions in wills and agreements made prior to death, such disposition has never been passed upon by the Illinois courts of last resort. There is no statutory authority in Illinois specifically providing for such disposition and it was planned, upon the advice of the ISMS general counsel, to introduce a bill in the 1965 session of the Legislature to specifically authorize this procedure. This suggestion was deferred due to the fact that the subject matter would have been controversial and it was felt that with the many built-in disagreements and differences of opinion in this session, it might be better policy to hold up until the 1967 session.

Illinois does have an Act covering deceased

bodies which are to be buried at public expense. These bodies may, under certain conditions, be used for advancement of medical science. The Act is set forth in paragraph 19, Chapter 91, Illinois Revised Statutes 1963, and is as follows:

"Superintendents of penitentiaries, houses of correction and bridewells, hospitals, state charitable institutions and county homes, coroners, sheriffs, jailors, city and county undertakers and all other state, county, town and city officers, in whose custody the body of any deceased person, required to be buried at public expense, is, shall, in the absence of disposition of such body, or any part thereof by will or other written instrument, give permission to any physician or surgeon licensed in Illinois, or to any medical college or school, public or private, of any city, town or county, upon his or their request therefor, to receive and remove free of charge or expense, after having giving proper notice to relatives or guardians of the deceased, the bodies of such deceased persons to be buried at public expense, to be by him or them used within the state, for advancement of medical science. Preference shall be given to medical colleges or schools, public or private and such bodies to be distributed to and among the same, equitably, the number assigned to each, being in proportion to the students of each college or school: except, if any person claiming to be, and satisfying the proper authorities that he is of kindred of the deceased asks to have the body for burial, it shall, in the absence of disposition of such body, or any part thereof by will or other written instrument, be surrendered for interment. Any medical college or school, public or private, or any officers of the same, that receive the bodies of deceased persons for the purposes of scientific study, under the provisions of this Act, shall furnish the same to students of medicine and surgery, who are under their instruction, at a price not exceeding the sum of \$5.00 for each and every such deceased body so furnished."

It should be noted that in the above law it is provided that disposition shall be made only in case the deceased has not specifically made disposition by his will or other written instrument. This would tend to support an argument that the deceased does have the right to dispose of his body as he sees fit, but to make it completely clear a new act specifically giving this power should, if possible, be adopted by the legislature.

The rather recent discovery that certain parts may be removed from a dead body and used in a living person has greatly increased the need for cadavers and parts thereof. Any one wishing to make a donation should so provide by his will and notify the institution to receive the body, or any part thereof, of this provision in his will and also notify the executor of the will and his next of kin, or whoever is the most likely to be notified immediately of his death, for time is of the essence in the case of transplants.

AUTOPSY

In Illinois, the heirs and next of kin can bring an action for mutilation of the body in those cases where an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed, in Illinois, when ordered by the coroner or upon written consent given by the next of kin.

THE MEDICAL WITNESS

It is difficult to find a field of law in which expert evidence is of greater importance than the testimony of the physician in accident cases. The carnage and mutilation on highways alone result in many thousands of lawsuits a year and the busy physician finds that attending court is a burden that often cannot be avoided.

There may be hope that the growing use of depositions will reduce some of the load from both physicians and attorneys as disclosure of evidence through deposition is likely to result in settlement before a case is brought to trial. Nevertheless, all signs indicate that the average practitioner can expect an increase in the number of times he will be called upon as an expert witness in the coming years.

It is suggested that, if the physician wishes to better prepare himself as to medical jurisprudence, there are a number of sources which can give him an insight into what he may expect in the forum and give him greater confidence as to this aspect of his practice. Such sources, without even the suggestion that the following begin to exhaust a listing, are:

1. Doctor and Patient and the Law, by Attorney C. Joseph Stetler and Alan R. Moritz, M.D., Director of the Institute of Pathology at Western Reserve University, Fourth Edition, published in 1962 by The C. V. Mosby Company of St. Louis.

2. Chapter III on Evidence in Law in Medical and Dental Practice by Lott and Gray, published in 1942 by The Foundation Press of Chicago.

3. Medical Trial Technique by Attorney Irving Goldstein and Willard Shabat, M.D., published in 1942 by Callaghan and Company of Chicago.

4. Lawyers Medical Cyclopedia of Personal Injuries and Allied Specialties, which consists of seven volumes and is an elaborate treatment of the subject; published in 1962 by The Allen Smith Company of Indianapolis.

5. The Rights and Rewards of the Medical Witness by Nordstrom, published in 1962 by Thomas Publishing Company of Springfield.

INTERPROFESSIONAL CODE FOR PHYSICIANS AND LAWYERS OF ILLINOIS

The following Interprofessional Code for Physicians and Lawyers of Illinois was drafted by a Special Committee on Medical-Legal Cooperation of the Illinois State Bar Association and the Liaison Committee of the Illinois State Medical Society to serve as a guide to physicians and lawyers. It has been approved by the governing boards of both

the Illinois State Bar Association and the Illinois State Medical Society.

Preamble

The purposes of this Code are to establish standards of practice and of ethical conduct for physicians and lawyers in those areas in civil cases where there is and will continue to be an interrelationship of medicine and law, and thereby to improve the practical working relationships of the two professions, to protect the legitimate interests and the rights of the patient-client, of the physician, the lawyer, and of society, and thereby to help advance the more effective administration of justice.

The provisions of the Code constitute recognition that the members of each profession have an obligation not only to the individual who obtains their advice and assistance but also to the community and society as a whole, and to all other members of their own professions. The objectives of the Code can be achieved only if the members of both professions acquaint themselves with these standards of practice and follow them, subject to rules of law and principles of medical and legal ethics.

ARTICLE I

ATTENDING PHYSICIAN'S MEDICAL REPORTS AND CONFERENCES

Purpose of Physician's Report

1. Information relative to an attending physician's treatment of a patient whose physical or mental condition is an issue in litigation is of prime importance to the parties involved in litigation. To properly prepare his client's case for trial and to be in a position to properly represent his client in settlement negotiations, the patient's lawyer has the duty of acquiring pertinent information from the attending physician. During the course of litigation, it becomes necessary for the lawyer to correspond with and confer with his client's physician and to obtain written reports from the physician.

Keep Complete Records

2. The attending physician should prepare, keep and preserve full and complete records of his examination, diagnostic findings (laboratory), and treatment of the patient.

Request for Report

3. When a medical report is desired by the lawyer, he should make a written request for it from the attending physician, and this request should be accompanied by a written authorization from the client for the release of the information sought from the client's physician. The request should ask the physician to give the following specific information:

- (a) History of the occurrence leading to the injury or condition, as given by the patient to the physician.
- (b) Pertinent subjective complaints elicited from the patient.
- (c) Pertinent objective findings made by the physician throughout the course of treatment.

- (d) The physician's diagnosis.
- (e) Interpretation of x-rays, electroencephalograms, electromyograms, and any and all other pertinent data used in the treatment and diagnosis (source and interpretation should be stated).
- (f) Treatment rendered by the physician to the patient.
- (g) The physician's opinion as to whether there is permanent residual from the injury or condition and the extent thereof.
- (h) The prognosis.
- (i) The physician's opinion as to the necessity of further medical or surgical treatment.

The request for a report should be accompanied by a statement that the lawyer will endeavor to provide for the payment of the physician's fees out of any settlement or satisfaction of judgment.

The Physician's Report

4. The physician has the obligation to cooperate with his patient's lawyer and should as soon as practicable after receiving the request for it supply the patient's lawyer with a written report. This report should be clear and concise and should contain specific responses to the elements enumerated in the lawyer's request for a report. In preparing the report, the physician should examine his own records and where practicable, the records of any hospital he deems necessary pertaining to the treatment of the patient.

The attending physician should not give written or oral reports concerning his patient to attorneys, adjusters, or investigators representing parties whose interests are adverse to those of the patient without express written authorization from the patient.

Report Should Be Complete

5. The report to the lawyer should be objective, impartial and complete. The attending physician should not give, and should not be asked to give a report that does not comply with these standards.

Conference Between Physician and Lawyer

6. Prior to the submission of a medical report by the attending physician to the patient's lawyer, conferences may be required between the patient's physician and lawyer. Conferences at the request of either the physician or the lawyer should be arranged at the mutual convenience of each. At the conference there should be candid discussion of the medical aspects of the litigation to promote complete understanding between the patient's physician and lawyer.

ARTICLE II

EXAMINING PHYSICIAN'S MEDICAL REPORTS

The "examining physician," as the term is used in the Code, differs from the "attending physician" and the "expert" in that he does not prescribe treatment and is not necessarily expected to testify at the trial. His examination is made at the request

of the lawyer for one or both of the parties or at the request of the court. Should he later testify at the trial he testifies as an expert.

Request for Examination and Report

1. Where the examination is made at the behest of either party, a written request for examination should be sent to the physician by the lawyer asking for the examination stating the nature of the examination desired.

The request should be specific and request the physician to give the following information:

- (a) Pertinent subjective complaints elicited from the patient.
- (b) Pertinent objective findings made by the physician.
- (c) The physician's diagnosis as of the time of the examination.
- (d) Interpretation of x-rays, electroencephalograms, electromyograms and any and all other pertinent data used in the diagnosis (source of interpretation should be stated).
- (e) The physician's opinion as to whether there is a permanent residual from the injury, and the extent thereof.
- (f) The prognosis.
- (g) The physician's opinion as to the necessity of further medical or surgical treatment.

Report of Examination

2. The examining physician should send the report of the examination to the lawyer requesting the examination as soon as practicable after the examination. The report should be clear and concise and should contain specific responses to the elements enumerated in the lawyer's request.

Report is Confidential

3. The examining physician shall not give medical information to the opposing lawyer without the authorization of the lawyer who requested the examination, unless the examination is pursuant to order of court.

Keep Complete Records

4. The examining physician should prepare, keep and preserve full and complete records of his examination and diagnostic findings (laboratory).

Report Should Be Complete

5. The report to the lawyer should be objective, impartial, and complete. The examining physician should not give, and should not be asked to give a report that does not comply with these standards.

Examination at the Request of the Court

6. Provisions for examination at the request of the court, and the procedure to be followed, are covered by rule of court or by statute.

Copy of Report to Employee in Workmen's Compensation Cases

7. In Workmen's Compensation cases, the examining physician selected by the employer is required

to deliver a copy of his report to the injured employee or his lawyer, unless the employee has a physician of his own selection present during the examination.

ARTICLE III MEDICAL FEES

Attending Physician

(1) The attending physician of a patient whose physical or mental condition is the subject matter in litigation may, in the manner provided by the Statutes of the State of Illinois, perfect his lien for medical fees for his services rendered to the patient. (See Appendix for suggested form of lien notice.)

(2) The physician should also notify the lawyer for the patient of his lien by sending him a copy of the Notice of Lien.

(3) The lawyer for the patient should explain to his client the nature of the lien and necessity for satisfying it out of any recovery. The lawyer should take all reasonable steps to assure payment for the physician's services out of any recovery made for the client. If the lawyer finds that he cannot accomplish this, he should notify the physician immediately so that he may take steps to enforce his lien. (See Appendix for suggested form of authorization to be used by lawyer.)

(4) In the event that the attending physician expends time in preparing a report, in appearing at a deposition or in court, or in any other manner for his patient, the physician shall be entitled to a reasonable fee from his patient. The lawyer shall take all reasonable steps to see that his client pays the said fee.

(5) The attending physician shall not charge his patient a higher fee because the patient may recover the amount of these charges as the result of a claim or litigation.

(6) The lawyer should not pay the attending physician's fee except with the client's funds.

(7) The physician's fee shall not be contingent upon the outcome of the litigation.

Examining Physician

(1) A physician who makes an examination at the request of a lawyer shall charge the reasonable value of his services so rendered on the same basis as if his services were not rendered to a patient in connection with litigation. The physician's charge for reports, conferences with the lawyer, and appearances at depositions and in court shall also be based upon the reasonable value of those services.

(2) The said charges shall be the obligation of the client and not of his lawyer. The lawyer shall make every reasonable effort to see to it that his client pays the fee of the examining physician for all services rendered by the physician to or in behalf of said patient.

(3) The examining physician's fee shall not be contingent upon the outcome of the litigation.

Experts

(1) The physician whose services may be rendered as an expert in connection with any phase of

litigation, shall not charge more than the reasonable value of his services. The fee shall be the obligation of the patient-client and not of his lawyer.

(2) The lawyer shall make every reasonable effort to see that his client pays the fee of the expert.

(3) The expert's fee shall not be contingent upon the outcome of the litigation.

ARTICLE IV

THE PHYSICIAN AT THE TRIAL OR HEARING ON DEPOSITION

Conferences Prior to Trial

(1) The lawyer and the physician should arrange to confer with each other before the physician testifies at any hearing, and if possible, before the trial commences. At the conference the common problems involved in the case should be discussed. The lawyer has the responsibility of acquainting the physician with any particular legal problems which might involve the physician, and with the assistance of the physician should determine the areas in which the physician will be called to testify. The lawyer should familiarize the physician with the contents of any proposed hypothetical questions.

(2) The physician should make every effort to cooperate with the lawyer in regard to this conference. Each should be mindful of the demands on the other's time in making appointments for conferences, in the time spent on conferences, and in notifying the other promptly if, for any reason, either is unable to attend the appointed conference. While the physician should recognize that he is not an advocate and the lawyer is, he should at the conference familiarize the lawyer with the medical problems involved, the areas in which he (the physician) feels qualified to testify, and the facts and opinions about which he is prepared to testify.

Court Arrangements

(1) The lawyer should make every effort to be economical in his use of the physician's time. He should give the physician reasonable advance notice of when and how long he shall be needed in court, advise the physician promptly of any changes in the time of his needed appearance, and should call the physician as a witness upon his arrival at court, with as little delay as possible.

(2) The physician has an obligation to be in court at the time requested. He should recognize that only a true emergency will excuse his nonattendance. In the event that such an emergency does arise, he should, as soon as possible, notify the lawyer who requested his appearance in court of his inability to be in court at the appointed time and also advise as to the earliest time he will be available to testify.

Subpoenas

(1) The lawyer should determine whether or not the physician should be served with a subpoena. If the physician is to be served with a subpoena, the lawyer should advise the physician of the reason

for serving him; for example, that service of a subpoena is necessary to lay the foundation for a continuance if the physician is unable to attend the trial due to an emergency or other cause. If service of a subpoena is to be had, the lawyer should advise the physician in advance, and if possible, arrange for the service of the subpoena at a time and place satisfactory to the physician.

(2) The physician should recognize that a lawyer may deem it necessary to subpoena the physician, and that the physician is obliged to answer the subpoena as any other citizen. He should cooperate with the lawyer with regard to the time and place of service.

Conduct as a Witness

(1) It is improper for a lawyer to attempt to color or otherwise influence the professional opinion of a physician.

(2) The physician's testimony should be unbiased and given in terms understandable to the jury. He should be prepared to testify in detail as to his qualifications, the medical facts in the case, and to give his frank and honest medical opinion in regard thereto. Technical or medical terms, if used, should be carefully and fully explained. The physician should remember that he is not an advocate trying a lawsuit, nor should he feel that he is taking sides on any particular medical issue or fact.

Conclusion

If the above interprofessional code for physicians and attorneys of Illinois was followed by all parties, the following results might well be attained:

1. A greatly improved understanding of each others problems by the members of both professions.
2. A considerable savings of time by all participants.
3. Better public relations for both groups.
4. Better and easier collections of fees.
5. Better and more efficient administration of justice.

A suggested form of physician's lien notice is as follows:

NOTICE OF LIEN
In favor of John M. Jones, M.D.
1424 Chestnut Street
Springfield, Illinois

Dated this.....day
of....., 19.....
TO:.....
.....
.....
I am advised that.....,

whose address is.....,
has a claim, right, or cause of action against you
for injuries received, resulting from an accident on
or about

You are notified that I claim a lien upon such
claim, right, or cause of action for reasonable
charges for medical services rendered said
..... on account
of said injuries, the total amount of such lien not
to exceed one-third (1/3) of any sums due or paid
to such injured person by compromise, settlement,
or satisfaction after the satisfaction of any attor-
ney's lien, if any.

This lien is claimed pursuant to an Act provid-
ing for a lien for physicians rendering treatment to
injured persons approved July 23, 1959 (Chap. 82,
Sec. 101.1 through 101.6, Ill. Rev. Stats., 1963).

Money paid in settlement of this claim or in
settlement or payment of any judgment or decree
on this claim is subject to this lien, and before
making settlement, you should consult with me and
see that this lien is satisfied.

.....
Signature

(This notice to be served on both the injured
person and the parties against whom such claim or
right of action exists, by certified mail or in person.)

Suggested form of authorization to be used by
lawyer:

(Place)
(Date)

"I,, hereby
authorize and direct.....,
my attorney, or attorneys to pay from the proceeds
of any recovery in my case to Dr.....
..... the reasonable amount
for professional services in the treatment of injuries
sustained by me and/or my wife and/or child or
children, as the case may be, in an accident which
occurred on....., 19.....,
said payment to include professional services hereto-
fore rendered and those rendered to the time of
the settlement or other disposition of my case for
the treatment of said injuries, and fees for testifying
in court."

"I further authorize said Doctor to furnish said
Attorney with any reports he may request in refer-
ence to my injury. I understand that this in no
way relieves me of my personal responsibility to
pay all such medical charges."

Witness
Signed

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County Medical Society, March, 1963

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Side effects and precautions: The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution**

Precautions and contraindications: This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or peria-
terial extravasation, both of which should be avoided. **More detailed professional information available on request.**

ADDENDA TO ISMS HOUSE OF DELEGATES

The following former Councilors and/or Trustees are entitled to vote in the House of Delegates by virtue of the fact that they are also Past Presidents of the ISMS:

Rolland L. Green, Springfield
James H. Hutton, Chicago
Everett P. Coleman, Canton
Robert S. Berghoff, Chicago
Irving H. Neece, Decatur
Percy E. Hopkins, Chicago
Harry M. Hedge, Chicago
Leo P. A. Sweeney, Chicago
Willis I. Lewis, Herrin
Arkell M. Vaughn, Chicago
Raleigh C. Oldfield, Oak Park
H. Close Hesseltine, Chicago
Edwin S. Hamilton, Kankakee
Harlan English, Danville
Edward A. Piszczek, Chicago

EX-OFFICIO MEMBERS OF THE HOUSE

(Floor privileges—without the right to vote)

FORMER COUNCILORS—or TRUSTEES

Charles P. Blair, Monmouth—Councilor from the 4th District
Earl H. Blair, Chicago—Councilor from the 3rd District
Fred C. Endres, Peoria—Trustee from the 4th District
W. W. Fullerton, Sparta—Councilor from the 10th District
Richard Greening, Chicago—Councilor from the 3rd District (resides in California)
George A. Hellmuth, Chicago — Councilor from the 3rd District (resides in Milwaukee)
Bernard Klein, Joliet—Trustee from the 11th District
Charles O. Lane, West Frankfort—Councilor from the 9th District
Warner H. Newcomb, Jacksonville—Councilor from the 6th District
G. C. Otrich, Belleville—Councilor from the 10th District

If there are other Councilors and/or Trustees who are not listed here, please so notify the headquarters office. This is the first time this list has been prepared.



REQUIREMENTS FOR CERTIFICATION

Members of the Illinois Medical Assistants Association, both singly and in groups, are working intensively this year toward earning their certification as administrative and/or clinical medical assistants. This requires many hours of study and also requires that the candidate be eligible to take the examination. To be eligible the candidate must:

1. Be at least 21 years of age
2. Be a high school graduate
3. Have a minimum total of three years experience in the office of a doctor of medicine, hospital, or clinic
4. Have at least twelve months continuous experience in the office of one doctor, hospital, or clinic
5. Request present employer to submit a brief letter of reference, which should include opinions as to the applicant's readiness for such testing, work impressions, and general capabilities. This letter is not submitted with the application, but mailed directly to the American Association of Medical Assistants

The following brief outline indicates the comprehensiveness of this examination:

SECTION I. Medical Terminology, Anatomy and Physiology

SECTION II. Personal Adjustment and Human Relations; Medical Ethics and Etiquette

SECTION III. Medical Law and Economics

SECTION IV. Office Skills and Procedures; Accounting; Credits and Collections

SECTION V. Written and Oral Communications; Records, Medical and Non-Medical

SECTION VI. Examination Room Techniques; Sterilization Procedures; Care of Equipment; Immunology and Injections

SECTION VII. Laboratory Orientation (Urinalysis; Hematology and Bacteriology), X-Ray, Electrocardiography, Basal Metabolism, and Physiotherapy.

Certification for Administrative Medical Assistant requires a passing grade in Sections 1, 2, 3, 4, and 5. Certification as a Clinical Medical Assistant requires a passing grade in Sections 1, 2, 3, 6, and 7. Any candidate has the privilege of attempting all seven sections for certification in both the administrative and clinical fields.

An example of the interest and enthusiasm shown by both the girls and their doctor advisors in the

certification program is typified in the study group Kane County has had operating since January 4, 1965. This group has been studying under Dr. Donald Dick of St. Charles one evening a week at his office. To date they have partially covered medical terminology and are now in the midst of anatomy and physiology. With the cooperation of Community Hospital in Geneva they have had the use of a blackboard, skeleton, and anatomical charts. Dr. Thomas Harwood, an advisor of the Illinois Medical Assistants Association, has supplied them with anatomical and pathologic specimens.

This group has a regular attendance with half of the chapter's members taking advantage of the course and attending every week. Some of the girls come from as far as twenty-five miles away each week. The sessions last two hours. A typical evening's study outline was:

I. Anatomy of Vision

- A. Eye
- B. Visual Pathways
- C. Cerebral Cortex

II. Physiology of Vision

- A. Accommodation
- B. Corresponding Points
- C. Visual Acuity
- D. Convergence
- E. Reflex Control of Pupil Size
 1. Accommodation—Consensual
 2. Light
 3. Association Reflex
 - a. Skin of Neck
 - b. Pain
 4. Protective
 - a. Blinking
 - b. Tears

III. Refractive Errors

- A. Myopia
- B. Hyperopia
- C. Presbyopia
- Astigmatism

IV. Visual Effects of Lesions

Textbooks were selected from the bibliography at the end of the study outline which is supplied free of charge to interested individuals by the American Association of Medical Assistants, 510 N. Dearborn Street, Chicago, Illinois 60610.

The aim of AAMA, IMAA, and your county chapter is to educate the medical assistant to do a better job for her doctor employer. Does your county have a chapter? Does your medical assistant belong to it? For information on forming a chapter write to the Illinois Medical Assistants Association, 360 N. Michigan Ave., Chicago, Illinois 60601.

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Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

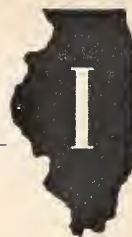
Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.



Society Elections

At their seventh annual meeting held at the Sherman House in Chicago recently, the Illinois Society of Internal Medicine elected the following officers for 1965-66:

President—A. Edward Livingston, M.D., Bloomington; President-elect—E. Richard Ensrud, M.D., Urbana; Secretary-Treasurer—Mervin Shalowitz, M.D., Skokie; Past President—Charles F. Downing, M.D., Decatur.

The following physicians were named Councilors for the current year:

Wright R. Adams, M.D., Chicago; Richard Allyn, M.D., Springfield; William B. Buckingham, M.D., Chicago; Edward W.

Cannady, M.D., East St. Louis; Charles Farnum, M.D., Peoria; Eliot F. Foltz, M.D., Winnetka; Franklin A. Kyser, M.D., Evanston; Frank B. Norbury, M.D., Jacksonville; Peter J. Talso, M.D., Chicago; William H. Wehrmacher, M.D., Chicago.

During the meeting, J. P. Revenaugh, President, Professional Business Management, Inc. and Vernon G. Tock, President, American College of Clinic Managers were featured on the panel discussion—"Managing the Internist Office."

The Society maintains executive offices at 360 North Michigan Avenue, Chicago.

(Continued on page 272)



Dr. Gonzalo Magsaysay (right), cousin of the late Ramon Magsaysay, former president of the Philippines, was named the outstanding surgical resident at Michael Reese Hospital, Chicago. Award presentation was made by Dr. Willis J. Potts, Chicago's pioneer blue baby surgeon. Dr. Magsaysay was honored, not only for his surgical skill, but for his personal interest in his patient's welfare. The \$500.00 award is given in memory of the late Dr. Charles A. Schiff, a dedicated Michael Reese surgeon.

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(Continued from page 268)

Chicago Pediatric Society Elects

The following new officers of the Chicago Pediatric Society were elected for the year 1965-66:

President: Mila I. Pierce, M.D., 920 East 59th Street, Chicago.

Vice President: Howard S. Traisman, M.D., 6354 N. Broadway, Chicago.

Secretary: Paul C. Tracy, M.D., 132 South Prospect Ave., Park Ridge.

Treasurer: Arthur W. Fleming, M.D., 2537 South Prairie Ave., Chicago.

Editor: Lawrence Breslow, M.D., 8424 Skokie Blvd., Skokie.

Executive Committee: Joseph R. Christian, M.D., Harry L. Faulkner, M.D., I. Pat Bronstein, M.D.

Appointment

Dr. Henry Rappaport has been appointed Professor of Pathology and Director of Surgical Pathology at The University of Chicago.

The appointment was announced by Edward H. Levi, Provost of the University.

Dr. Rappaport was Professor of Oncology at the Chicago Medical School prior to his appointment at the University. He joined the Chicago Medical School faculty in 1958.

Dr. Rappaport has served on the faculty of George Washington University School of Medicine, Washington, D. C., and the staff of the Armed Forces Institute of Pathology, in Washington.

From 1954 until 1958 he was Pathologist and Director of Laboratories at Mount Sinai Hospital, Chicago.

Rules on Radiation Hazards

Copies of "Rules and Regulations for Protection Against Radiation Hazards," as amended in September, 1964, are available from Dr. Franklin D. Yoder, Director of the Department of Public Health, State Office Building, Springfield. The booklet contains all the information that users of ionizing radiation need to comply with the Illinois Radiation Protection Act.

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SPECIALTY REVIEW COURSE IN MEDICINE,
Part I, September 13
SPECIALTY REVIEW COURSE IN PEDIATRICS,
Parts I & II, September 27
SPECIALTY REVIEW COURSE IN GYN-OB, Two Weeks,
October 25
PRINCIPLES OF OPERATIVE SURGERY, Two Weeks, October 4
SURGERY OF STOMACH & DUODENUM, One Week,
September 20
PROCTOSCOPY & SIGMOIDOSCOPY, One Week, September 13
TREATMENT OF VARICOSE VEINS, One Week, September 13
SURGERY OF THE HAND, One Week, September 13
PEDIATRIC SURGERY, One Week, September 20
SURGERY OF FACE & MOUTH, One Week, October 11
ADVANCES IN SURGERY, One Week, October 4
ADVANCES IN MEDICINE, One Week, October 4
ADVANCES IN OB-GYN, One Week, October 4
FRACTURES & TRAUMATIC SURGERY, Two Weeks,
September 20
BASIC ELECTROCARDIOGRAPHY, One Week, September 27
CLINICAL USES OF RADIOISOTOPES, Two Weeks, October 4
VAGINAL SURGERY, One Week, September 13
FLUIDS & ELECTROLYTES, One Week, September 13
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

*Information concerning numerous other
continuation courses available upon request.*

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OBITUARIES

Walter W. Armstrong*, Chicago, died July 1, aged 78. He was a graduate of Jenner Medical College in 1913. Before his retirement in 1953, Doctor Armstrong had been on the staffs of Ravenswood & Swedish Covenant hospitals and supervisor of the communicable disease section of the Chicago health department.

C. Spencer Bond, Decatur, died June 3, aged 56. A graduate of the University of Illinois College of Medicine in 1939, he specialized in psychiatry. He was a staff member of the Macon County Mental Clinic where he had also served as director. He had also been director of City Public Hospital. William H. Bowman, Jr., Chicago, died June 3, aged 59. A graduate of Meharry Medical College, Tennessee, in 1931, he was a staff member of Provident hospital.

Edward W. Cobb, Florida, formerly of Chicago, died June 2, aged 74. He was a graduate of the Hahnemann Medical College in 1914.

Ester F. Quigley Conole, Chicago, died June 7, aged 68. A graduate of Loyola University School of Medicine in 1919, she had been a staff member of St. Bernard's hospital.

John J. Eichstaedt*, Chicago, died July 1, aged 67. A graduate of Chicago Medical School in 1922, he had been a staff member and later a trustee and a member of the board of directors of Henrotin hospital.

Stephan Gere*, Waukegan, died June 22, aged 54. A graduate of Università degli Studi di Bologna, Facoltà di Medicina e Chirurgia, Italy, in 1935, he was a staff member of Victory Memorial hospital.

James L. Hall, Sr.*, Chicago, died June 10, aged 73. A graduate of Rush Medical College in 1926, he specialized in internal medicine.

Robert N. Hedges, Sr.*, Wisconsin, formerly of Chicago, died June 20, aged 73. A graduate of Northwestern University Medical School in 1948, he specialized in internal medicine. Formerly an instructor at Northwestern and a consultant at Presbyterian-St. Luke's hospital, he retired in February of this year. He was an emeritus member of ISMS.

Raymond E. Holben*, Quincy, died June 10, aged 86. In 1901 he was a graduate of Washington University School of Medicine, St. Louis. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Nicholas H. Kern*, Chicago, died April 29, aged 83. He was a graduate of Northwestern University Medical School in 1904. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Daniel J. Lynch, Chicago, died June 26, aged 95. A graduate of Rush Medical College in 1896, he became an E.E.N.T. specialist. He retired in 1949.

John B. Moore*, Benton, died June 9, aged 81. He was a graduate of Rush Medical School in 1901. During his 50 years of practice he established the Ziegler and the Moore hospitals and was an emeritus member and a member of the Fifty Year Club of ISMS.

Clarence H. Payne, Chicago, died June 7, aged 73. A graduate of Rush Medical College in 1922, he specialized in pulmonary diseases. He was formerly head of interns at Provident hospital and was on the staff of the Chicago Municipal Tuberculosis sanitarium.

Joseph B. Salberg*, Wilmette, died June 21, aged 75. He was a graduate of the University of Colorado School of Medicine, Denver, in 1917.

Frederick von Brauchitsch*, Glencoe, died June 21, aged 63. A graduate of the University of Colorado School of Medicine, Denver, in 1931, he was a staff member of Grant hospital for 30 years.

Henry O. Wernicke*, Skokie, died July 3, aged 78. A graduate of Rush Medical College in 1911, he specialized in surgery. A staff member of Wesley Memorial hospital, he taught surgery at both Northwestern and the University of Illinois medical schools. He was a member of the International College of Surgeons, an emeritus member and a member of the Fifty Year Club of ISMS.

Edward W. Westland*, Florida, formerly of Oak Park, died June 10, aged 79. A graduate of Rush Medical College in 1915, he was executive of the surgical staff of West Suburban hospital for 30 years. He was an emeritus member and a member of the Fifty Year Club of ISMS.

*Indicates member of Illinois State Medical Society.



a Private Psychiatric Center at Jacksonville, Illinois, since 1901

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.

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Illinois Medical Journal

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copies available at cost of 75 cents. Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601. Copyright 1965, The Illinois State Medical Society.



Burtis E. Montgomery, M.D.

— president's page —

COOL HEADS NECESSARY

SINCE MEDICARE became law on July 30, many doctors have been asking, "What next? What do we do now?"

The newspapers have answered with a good bit of rhetoric on the possibility of doctors boycotting the government program, and surely some of them will . . . as it is their right to do. But most of us will go along, much as we have been, rendering medical care to those who need it, because the principles that cause us to put our patients' interests first will continue to be our foremost consideration.

Essentially, the practice of medicine is an individual matter . . . that is why we fought so valiantly and, ironically, lost to the forces of regimentation that were stronger than the forces of freedom and independence. And because of this spirit of independence, which, perhaps incongruously, can operate amicably in vast areas where teamwork and cooperation are vital, the doctor is now called upon to make the decision alone: to participate or not participate in the practice of medicine with the federal government looking over his shoulder.

Discouragement, resentment, and other negative emotions are perfectly natural at a time like this. For 20 years the Washington planners have attempted to squeeze the foot of socialized medicine through our door. And now they have succeeded. From now on things can only get worse . . . not only for us, but think what the Secretary of HEW and Wilbur Cohen have bought.

They realize that administering this complicated and far-reaching law will be no Sunday school picnic and they'll be looking for all the help they can get. If you don't

think there are plenty of willing helpers waiting in the wings, you are mistaken. The planners and the spenders are always there and if we do not get in ahead of them, blame for what happens will be ours, because the responsible parties in government will not be able to handle the staggering job alone.

Therefore, while it may be every individual physician's right to participate or not participate in this program as he chooses, it seems to me that it is to our advantage to keep as close to the situation as possible so that we can protect our profession from those who would destroy it selfishly or through ignorance.

The American Medical Association has taken the stand that organized medicine should "give advice and guidance to the secretary of health, education, and welfare to the end that programs developed and regulations promulgated will provide the stated benefits in the most meaningful manner to our patients with a minimum of disturbance and inconvenience to the medical profession."

At the same time, the AMA Board of Trustees has urged all physicians to "face the problems ahead with restraint, a clear mind, and unity." To my way of thinking, we have no other choice. The solidarity of organized medicine from the county level up through the state societies and the AMA is more important now than ever before.

We cannot afford to abdicate our responsibilities. If we do, mass confusion can only result. Cool heads and the established lines of communication existing throughout our organized societies will be most necessary in the trying times ahead.



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The year was 1859. The seeds of secession were being sown . . . but America's growth remained unchecked. The word to the youth of the day was 'go West'. . . and a continuous line of rails linked New York to the bustling metropolis of Chicago. It was here, on October 9th, that Northwestern University Medical School, first organized as the Medical Department of Lind University, opened its doors to 33 students.

Even in its very earliest years, Northwestern University Medical School was a pioneer in the advance of medical education. So numerous were the innovations in medical instruction established there, in fact, that the initial founders

came to be called the "Apostles of Reform."

This progressive spirit, is, today, a familiar tradition . . . a tradition that has become a cherished symbol of Northwestern's commitment to the future.

An oil painting of Northwestern University Medical School, as reproduced on the following pages, is the most recent addition to the gallery comprising Collegia Medica Squibb. As part of this program, E. R. Squibb & Sons has presented the original work of art for permanent display at the school. A full color print of the artist's painting, in a size suitable for framing, will be sent to each alumnus of the school.



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ABSTRACTS OF BOARD ACTIONS

MEETINGS OF JULY 31, AUGUST 1, 1965

NEW SUBCOMMITTEES FOR LEGISLATIVE GROUP

The Board of Trustees has approved a request from the Legislative Committee to set up a series of subcommittees to study six areas in which legislation is anticipated during the 1967 General Assembly session. These include licensing of hypnotists, electrologists, etc.; medical licensees (chiropractors, optometrists, etc.); physician supply (citizenship restrictions, new medical schools, etc.), and new public health programs.

FUNDS FOR MEDICAL MUSEUM NOT AVAILABLE

General counsel for the Society has been authorized to decline the offer to participate in the proposed medical historical museum in Springfield if funds for participation have not become available to supplement the arrangements made by the House of Delegates in May.

AMA DELEGATES ASKED TO ATTEND BOARD MEETINGS

All delegates and alternate delegates to the American Medical Association will be invited to attend both Saturday and Sunday sessions of the ISMS Board of Trustees in order to better represent the Society at AMA sessions.

NURSING SURVEY ENDORSED

A proposed survey of nursing needs and resources in Illinois, to be conducted by the Illinois League for Nursing and the Illinois Nursing Association, has been given a formal endorsement of the ISMS Board of Trustees although no Society funds will be made available for the project.

NUTRITION CONFERENCE OCTOBER 8

The ISMS Committee on Nutrition will be co-sponsor of a Conference on Nutrition in Medicine Oct. 8 at the Hotel Faust in Rockford. All members of the Society are invited to attend.

STROKE PROGRAM APPROVED

The ISMS Board of Trustees has approved in principle a stroke program to be conducted by the Illinois Heart Association. The program embodies the aims of the ISMS Committee on Aging for developing community projects in this area. No county will be used as a pilot area without the consent of the local medical society.

VOLUNTARY HEALTH AGENCIES

The Public Relations Committee has been authorized to establish a subcommittee on Voluntary Health Agencies to help a council similar to the Illinois Association of the Professions.

(Continued on next page)

Some people get away from colds and sinusitis



by getting away from frigid weather



... but if your patient can't get away, relieve sneezing, running nose, and congestion of colds and sinusitis all day or all night with one

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Summary of contraindications, cautions and side effects: Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction or bladder neck obstruction. Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease. Drowsiness; excessive dryness of nose, throat or mouth; nervousness or insomnia may occur on rare occasions but usually are mild and transitory.

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ABSTRACTS OF BOARD ACTIONS---(CONT'D)

MEETINGS OF JULY 31, AUGUST 1, 1965

PUBLIC AFFAIRS CIRCUIT RIDERS

The Public Affairs Committee has activated a program called "Public Affairs Circuit Rider Meetings" to be held in each of the downstate congressional districts and possibly in Cook County. The first meeting is scheduled for Sept. 29 in Rock Island.

SIMPLIFIED DISCIPLINARY PROCEDURES STUDIED

The Committee on Constitution and Bylaws, at the request of the Ethical Relations Committee, is studying the chapter in the ISMS Bylaws pertaining to discipline to see if it might be possible to simplify some of the procedures outlined for county medical societies. The Committee, in cooperation with legal counsel, will attempt to develop a chapter that will be easier for the county Ethical Relations Committees to follow.

STUDY OF EYE INJURIES

The Illinois Society for the Prevention of Blindness has been given the ISMS Board of Trustees approval and support for a statewide survey of eye accidents. The survey is planned in cooperation with the Chicago Ophthalmological Society, the Illinois Hospital Association and the National Safety Council.

FEE SCHEDULE REPORT DUE IN OCTOBER

The Committee on Fee Schedules has been reviewing the Society's basic policy regarding medical care for the needy; recent AMA policy on fee schedules; procedures following in other states, and a table for comparing fee schedules used in Illinois. It expects to complete a preliminary report in this area in time to make recommendations to the Board of Trustees in October.

DEPENDENTS MEDICAL CARE PROGRAM

The Dependents Medical Care Program contract (with Blue Shield as fiscal administrator), which came up for renewal in August, has been renegotiated for only 90 days, rather than the usual one year, in order that future dealings in this area not be prejudiced.

SEX EDUCATION RECORDS INTRODUCED

The Public Relations Committee announces introduction of Dr. SIMS sex education records for parents and children. Cost of production was underwritten by the Family Information Center, Chicago.

RELEASE OF MEDICAL RECORDS

The Committee on Hospital Relations will be represented on an ad hoc committee to develop guidelines for hospitals and insurance companies governing the release of medical record information.



Case History

GOUT AND DIABETES

**Report of a Case With Severe Diabetes
And Polyarthritic Non-Tophaceous Gout**

D. J. Chang, M.D./Freeport

IT HAS BEEN PREVIOUSLY REPORTED that diabetes and gout in the same individual are rare^{1,2,3,4,5} and heredity appears to be important in both diseases.⁴ It has also been stated that there is improvement in the clinical course of gout with the appearance of diabetes in the same individual and usually the diabetes is of mild nature, being easily regulated by dietary regime or minimal doses of insulin.^{1,2} On occasion as is here, there is divergence from the usual clinical picture which is worth mentioning, not only because of the rarity of this condition but because the pathophysiological explanation is not clearly understood.

Case Report

This 46 year old white male was admitted to the hospital because of tiredness, frequency of urination and thirstiness which were present for two weeks. He gave a history of having had gout for seven years for which he was treated with colchicine and an unknown uricosuric agent. He could not recall any member of the family having

gout but a maternal aunt developed diabetes in her later life. He weighed 289 pounds and except for mild pigmentation of the axillae, the physical examination was essentially not remarkable. There were no tophi present and the retinae were normal. The fasting blood sugar was 300 mg. per cent.

The blood count revealed 13,200 leukocytes with 70 segmented neutrophils, 24 lymphocytes, and 6 monocytes, with a hematocrit of 43 volumes per cent and a hemoglobin of 14.8 grams per cent. The urinalysis showed a specific gravity of 1.030, pH of 5.5, occasional leukocytes and hyaline casts, and 4-plus glycosuria with a large amount of acetone. The plasma acetone determination was strongly positive. The serological test for syphilis was negative. The serum amylase was 72 Somogyi units, the leucine amino-peptidase test was 138 units, and the T-3 thyroid test was 13.6 per cent. The electrocardiogram showed non-specific T-wave changes and the chest x-ray showed linear atelectasis in both lung bases, normal heart configuration but a slightly tortuous aorta. He was put on a 1000 calorie diabetic diet and was given

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insulin to reduce his blood sugar. During the fourth hospital day, in addition to blurring of vision, he complained of severe pain in his left knee and milder but severe pain in the first metatarso-phalangeal joint of his left foot. The left knee was moderately swollen, slightly erythematous and extremely tender. The left first metatarso-phalangeal joint also was slightly swollen and erythematous and very tender. A serum uric acid determination showed 6.5 mg. per cent. He was then started on colchicine and probenecid therapy.

Except for blurring of vision his response thereafter was uneventful and he was discharged on the ninth hospital day with 60 units isophane insulin, 1000 calorie diabetic diet, colchicine and probenecid medications. The first monthly follow-up showed good progress with normal uric acid determinations, normal fasting blood sugars, and about seven pounds loss in weight. He had one attack of gouty arthritis of the left knee which responded well to colchicine. Subsequent evaluations for two months revealed normal fasting blood sugars with daily administrations of 50 units of isophane insulin, a fourteen pound weight loss, improved general well-being and vision although he had two attacks of gout with continued probenecid therapy.

Discussion

The emphasis of familial background in both diabetes and gout has been adequately discussed by Ishmael¹ and the rarity of both conditions occurring in the same person has been stressed before. Engelhardt and Wagner³ stated that only 5 to 8 per cent of all cases of arthritis are gout and they quoted Seckel as showing the incidence of gout among 430 diabetics as 2.1 per cent. In their association in a large diabetic clinic they were able to report only one case with both conditions occurring simultaneously although they felt that the triad of gout, diabetes, and obesity should occur more frequently than the literature would indicate. Bartels, Balodimos, and Corn¹ added 38 other cases of their own and gave the findings of Joslin as one gout in 1,500

cases of diabetes, whereas Talbott had reported only two cases in his book on gout. Beckett and Lewis² were able to report on eight other cases and they quoted Van Noorden in a survey from Germany as showing eight per cent of all types of gout in diabetic individuals.

It has been assumed that the incidence would probably be higher if one facet of the triad is found and the other two are investigated³ and two other studies showed abnormal carbohydrate tolerances in gouty patients much higher than the reported incidences of 2 to 8 per cent.^{5, 6} On the other hand, the occurrence of gout itself is rather low. Wyngarden⁷ stated that if 4 per cent of the 12,000,000 arthritics have gout then the incidence in the general population would be 274 per 100,000 or 0.27 per cent. Likewise, Renold and Cahill⁸ concluded that 3.5 per cent of the population in the United States are likely to have diabetes. However, the association of diabetes and gout in the same person is even less frequent than either disease alone. That the occurrence of diabetes following gout in the same individual is more frequent than the occurrence of gout after diabetes has been shown by Bartels, Balodimos, and Corn¹ who encountered 25 of 38 patients with gout well-established before diabetes was discovered and by Beckett, and Lewis² who reported 6 of 8 cases.

The appearance of diabetes seems to have an effect on gout has been shown and most cases have improvement with the diabetic state remaining of mild nature. Beckett and Lewis² reported all eight cases to have mild diabetes and stated that insulin is rarely required for its treatment. It was presumed by them that diabetes, in some way, increases the excretion of uric acid. Bartels, Balodimos and Corn¹ stated that only two of their 38 cases required 30 or more units of insulin and one of the two had diabetic retinopathy, whereas Weiss, Segaloff, and Moore³ reported only one of their cases with disturbed carbohydrate metabolism required insulin.

The appearance of diabetes after gout has been postulated to be due to a diabeto-

genic effect of an abnormal uric acid product which is related to alloxan and is a normal intermediary product of purine metabolism.^{5, 9} It selectively injures the beta cells of the pancreas, but only in the presence of subnormal level of glutathione in the blood.⁹ The development of hyperuricemia with adrenocorticotrophic hormone and adrenal corticosteroids have been demonstrated⁹ and recently the development of gout and diabetes with the administration of chlorothiazide¹⁰ have been thought to be due to the action on the pancreas as responsible for diabetes.¹¹

This case presented some findings of unusual interests. The patient showed the typical triad of findings of gout, diabetes and obesity³ and a family history of diabetes but none for gout. He was presumably treated with probenecid but the use of corticosteroids has not been ascertained. He developed ketosis with the onset of symptoms of diabetes and in addition to his dietary regime he required 60 units of insulin to regulate the blood sugar. He did not have diabetic neuropathy or retinopathy and there was no evidence of tophi. With the control of his diabetes he did not have immediate amelioration of his gout and he required continued medications with colchicine and probenecid. That the institution of insulin into the treatment of diabetes provoked the gouty attacks² cannot be maintained inasmuch as he showed the same frequency of symptoms prior to the discovery of his diabetes. In addition, he did not show findings of pancreatitis as suggested by pos-

sible occurrences in other patients given chlorothiazide.^{10, 11}

Summary

A case of gout, diabetes, and obesity is reported with the development of ketosis and regulation of the diabetes with 60 units of isophane insulin but with no reduction of the frequency of polyarthritic gouty symptoms. The rarity of the condition is stressed but the expected finding of clinical improvement for gout is not demonstrated. A review of the literature has shown no cases reported with the development of ketosis and the use of such large doses of insulin for improvement. The explanation is not apparent for his clinical course.

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SPECIAL GROUP RATES FOR AMA PHILADELPHIA MEETING

If you are planning to attend the Clinical Session of the American Medical Association in Philadelphia, November 28-December 1, consult page 345 in this issue for the special group rates available to ISMS members and their families through United Air Lines.

DIAGNOSTIC SCREENING TESTS IN MENTAL RETARDATION

Albert R. Rosanova, M.D., F.A.C.B., D.A.B.B.*

Henry Niemeyer, M.D.*

Simon Markiewicz, M.D.*

Theodore Compall, M.D.*

THANKS TO DR. GUTHRIE¹ and his screening test for phenylketonuria, a great deal of interest has been aroused in diagnostic screening tests for conditions found in the field of mental retardation. Our paper entitled, "Enzymes in Mental Retardation" which appeared as Part I in the July, 1964 issue and as Part II in the Sept., 1964 issue of the *Illinois Medical Journal* lists more than 25 different conditions which are due to inborn errors of metabolism.²

In the past few years, every few months another newly discovered condition has been added to this list. Therefore, it became apparent to us several years ago that a diagnostic screening type test was sorely needed in this field. As we all know, the particular conditions in this list are such that if the diagnosis is made within the first few weeks of an infant's life and appropriate dietary treatment instituted, then a whole lifetime of mental retardation can be avoided for this individual. This fact alone well warrants diagnostic screening tests in mental retardation.

Today, I am happy to report what appears to be very inexpensive, easy, fast, and highly reproducible methods for screening the many inborn errors of metabolism causing mental retardation. Furthermore, the amount of specimen needed from the patient is only a matter of a few drops. reliable analytical tool in the study of vari-

Methods

Since the researches of Consden, Goren, and Martin³ in 1944, paper chromatography has come to stay as a simple, rapid, and

ous problems in biochemistry. The technics used by us are all standard chromatographic procedures and may be found in such texts as "Chromatographic and Electrophoretic Techniques" by Ivor Smith,⁴ or "Paper Chromatography and Paper Electrophoresis" by Block, Durrum, and Zweig.⁵

In order to standardize procedures as much as possible, all blood or urine specimens are collected early in the morning before breakfast (fasting specimens). Capillary heel blood from an infant is adequate. The urine is standardized by adding 1 drop to a Whatman filter paper No. 1, letting dry, then adding Jaffee's⁶ reagent for creatinine (picric acid 1% in 55% alcohol, followed by potassium hydroxide 5% in 80% alcohol). Letting dry again and comparing the red spots of creatinine (on yellow background) to known solutions of creatinine concentration. This is done because too dilute urine might cause an aminoaciduria to be overlooked; or, conversely, very concentrated urine might lead to wrong interpretation of a normal amino acid urinary pattern.

Certain precautions are taken in order to insure reproducibility of the results obtained. For example:

1. About 200 cc. of solvent is placed in the developing tank usually 1 hour before use so that the atmosphere in the tank is saturated with solvent vapors when the tank is used.
2. A constant temperature is held in the room where the chromatography tanks are used.
3. This room is kept free from all fumes and all chemical odors.

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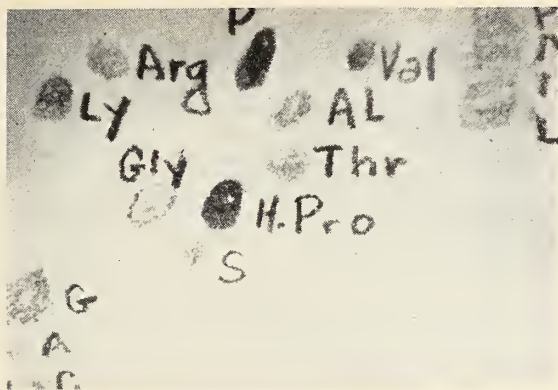


FIGURE 1. Amino acids in blood.

4. The subsequent spraying of the chromatogram is done under a ventilated hood and in a different room than the one in which the developing tanks are kept.
5. The tank cover is applied immediately after loading the tank with the solvent or with the chromatography papers, and is kept in place.
6. An automatic, disposable, capillary pipette which delivers a standard-sized drop of specimen is used for spotting the chromatography paper.
7. The solvent must always be just below the spot on the chromatography paper and never above it.

Method for Amino Acids

With the use of an automatic, disposable capillary pipette a standard-sized, small drop of blood or urine is applied to Whatman No. 1, 10", Chromatography paper at a spot exactly 1" from the bottom of the paper and 1" from the left hand side of the paper. The exact spot should have been previously marked off lightly with a lead pencil. A ruler is used for accuracy.

This spot is dried and autoclaved at 136° C for three minutes. The paper is then placed in a frame which fits a 10" Smith Universal Chromatography Tank.

The solvent used in the first run is 1,2-butanol and 3% ammonia in a 5:2 ratio.⁷ The spotted papers are left in the tank to develop overnight. They are removed from the developing tank the next morning and dried either at room temperature or in an oven at 60° C. After drying the chromato-

gram is placed with the left border down into a second tank with a second solvent consisting of 2,2-butanol, formic acid, and water in a 15 to 5 to 2 ratio, respectively. This is also left in the developing tank overnight.

The next morning it is removed from the tank and dried as before. Then a ninhydrin spray is applied, saturating the chromatogram. This is dried and read. (See Figures 1, 2, 3, 4, 5 and 6.)

The amino acids all stain purple excepting for proline and hydroxyproline which stain yellow. The only amino acid missing on this chromatogram is citrulline⁸ because it is overlapped by the glutamine. Therefore, a photo can be taken of this chromatogram at this point or a readout can be done with a densitometer. What was formerly the left hand side of the chromatography paper is now dipped into Ehrlich's reagent and dried. All of the purple spots due to the ninhydrin fade away and a bright pink spot appears where the glutamic acid was if there is present a concentration of citrulline in 10 mgm per 100 cc. or more. This citrulline can also be quantitated with a densitometer.

Method for Lipids

Since most of the lipid inborn errors of metabolism are in the phospholipid group, we have been routinely doing a non-dimensional separation of the lipids using Schleicher and Schull Chromatography paper No. 20436 which is acidified with acetic acid vapors by the manufacturer.⁹ (Although a two-dimensional chromatography of the

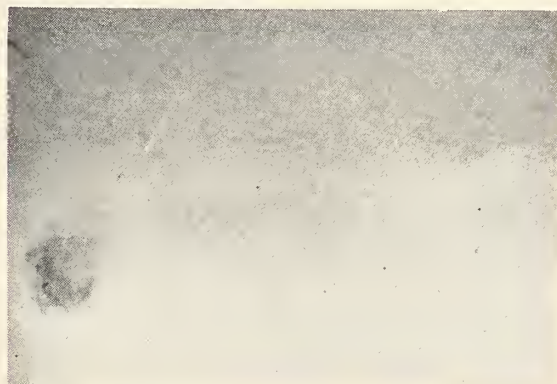


FIGURE 2. Citrulline.



FIGURE 3. Amino acids in urine.

lipids using different solvents for each dimension can be easily done with this same paper.)

A spot of blood or urine is placed on this chromatography paper at the proper site. The spot is dried and the chromatography paper is then placed in a developing tank with a solvent consisting of chloroform, methanol, and water in a 14 to 6 to 1 ratio. This solvent is very volatile and must be made fresh if more than 4 hours old. Usually, it takes about 50 minutes for the development of this type of chromatogram. The chromatogram is then removed from the developing tank and dried. The paper is then sprayed with a molybdic acid spray (modified Hanes-Isherwood reagent).¹⁰ It is then heated at 85° C for 7 minutes and kept in the air until blue spots show the positions of the phosphatides. The phosphatides may also be visualized by placing the chromatogram in a chamber filled with iodine¹¹ vapors (vapors are made by placing iodine crystals on bottom of chamber). The lipids stain yellowish-brown with the iodine vapors.

Quantitation can be done with a densitometer, although this must be done immediately upon staining with the iodine vapors because the iodine will re-evaporate in a short time, leaving a colorless spot. However, if the chromatogram is placed back in the iodine vapor chamber, the yellowish-brown spots re-appear.

Visualization of the phospholipids and other unsaturated fats can be done under

the ultraviolet light since these fluoresce under this light. 2,7 Dichlorofluoresceine spray applied to the chromatogram will make these spots fluoresce even more.

Method for Carbohydrates

The specimen is spotted as usual and dried. The spotted chromatography paper is placed in a developing tank in which is a solvent of ethyl acetate, pyridine, and water¹² in a ratio of 12 to 5 to 4. Development is allowed to proceed for 3 hours. The chromatogram is then removed from the tank and dried in an oven or in the air. The left border is then placed downwards in a developing tank with a second solvent of liquid phenol and water in a 5 to 1 ratio, for another three hours. Remove the chromatogram from the developing tank and dry. Spray with ammoniacal silver nitrate. Heat in an oven at 105° C for 10 minutes until reducing sugars appear as brown spots.

Conclusions and Discussions

We have been trying to do the chromatography of the amino acids, lipids, and carbohydrates all on one spot of blood or on one spot of urine but have not succeeded. However, we have been able to do the chromatography of lipids first with the chloroform, methanol, water solvent previously mentioned; drying the resultant chromatogram; and then doing a two-dimensional amino acid chromatography as previously described. We have found that by doing this the heating of the blood spot

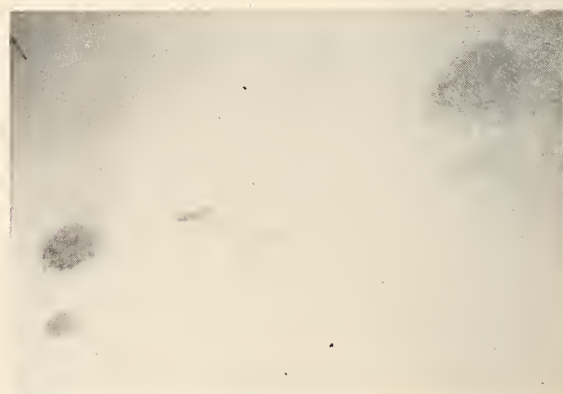


FIGURE 4. Urine in phenylketonuria.

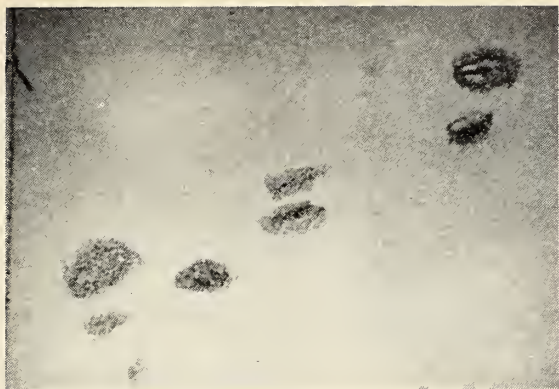


FIGURE 5. Hartnup syndrome.



FIGURE 6. Multiple vitamin deficiency.

in an autoclave becomes unnecessary. It is possible that the alcohol coagulates the proteins^{13,14,15,16,17} in the blood spot and thus takes the place of the heating in the autoclave. Whether or not we succeed in doing the chromatography of lipids, amino acids, and carbohydrates all from one spot of blood or urine actually doesn't matter, since three drops of blood and four drops of urine are not too excessive demands for specimens.

Because there are certain disorders in which the amino acids in the blood are unaltered or only slightly altered, whereas those in the urine are markedly altered; therefore, we can see the value of running the chromatogram on both the urine and the blood specimens. Common examples of these are: Cystinuria, Hartnup disease, Arginosuccinic aciduria, Cystathioninuria, Glycinuria, Galactosemia, Wilson's disease, Cystinosis, and the Fanconi Syndrome.¹⁸

Summary

In closing, I wish to state that if we can save even one small child from a lifetime of blackout and isolation by the use of diagnostic screening tests such as I have outlined here; it is well worth the effort. It has been estimated that the state will save approximately \$200,000.00 for each child that is prevented from becoming mentally retarded since it takes approximately this much money to keep an individual institutionalized throughout his lifetime.

Last, but not least, besides this great fi-

nancial savings to the community, we must also remember that the mentally handicapped child is also a child of God and as such deserves and is worthy of this help.

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THE MATERNAL INSTINCT

IN CANCER CONTROL

August F. Daro, M.D. and Harvey A. Gollin, M.D.†/chicago*

THE AMERICAN CANCER SOCIETY states that uterine cancer, once a most dreaded form of disease, could be practically eliminated as a cause of death if every adult woman would have a Papanicolaou smear test as a part of an annual routine health check-up. It also states that in 1961, 14,000 women died unnecessarily of cancer of the uterus. A Papanicolaou smear could detect most cervical cancer at a highly curable noninvasive stage. Yet, so far, according to statistics, less than 10% of adult women in the United States have been tested.

The American Cancer Society, the American Medical Association, women's clubs and magazines, the newspapers, radio and television have performed a mammoth job encouraging women to have annual cancer checkups. Yet the above statistics prove that we have not been successful in convincing women of the tremendous life saving importance of these checkups. Why does she not automatically avail herself of these tests? The answer is a many faceted one but one aspect could very well be that we have failed in providing her with an unselfish motivating force which would impel her to present herself voluntarily for periodic checkups.

From clinical experience I have found the maternal instinct to be one of the greatest motivating forces in a woman's behavior. The same women who fail to present themselves for periodic checkups

because of fear, modesty, dislike of pelvic examinations, lack of time or frugality are oftentimes the same ones who, when the maternal instinct prevailed to the extent of their wanting to become pregnant, would come to the office as frequently as requested and would submit themselves to various tests, painful or otherwise, sometimes including surgery. Under the influence of this powerful mother instinct, fear, modesty and frugality vanished. It has also been my observation that most women who are reluctant in making routine future appointments will do so unhesitantly when they feel they are doing it for the welfare of their families.

The maternal instinct impels a woman to seek a husband and to raise a family. It is the impelling force, if the need be, in her working day and night for the material needs of her family and the reason for her spending hours in preparing a dinner for them—something which she unselfishly would not do just for herself. It is the motivating force when, if her husband is ill, she insists he see his doctor, or if her child is ill or in need of prophylactic medical care, she will see to it that this care is obtained. This maternal instinct motivates her in creating a home filled with warmth and affection but unfortunately because of it most women become concerned with the health and welfare of their families to the extent that they unselfishly and instinctively neglect their own.

Should we not then take advantage of this powerful maternal instinct which motivates women to administer to her family with such instinctive devotion by channel-

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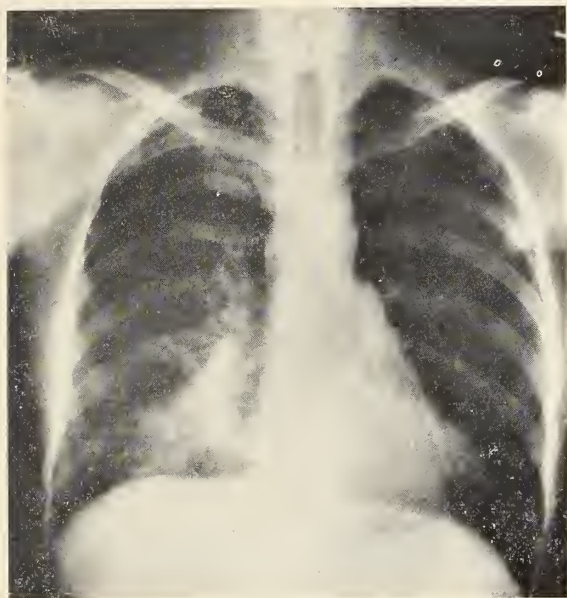


Fig. 1

THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

A 42-year-old man was admitted to the hospital because of a fever and cough. No history of previous surgery was obtained.

Physical examination revealed rales at the right base and increased dullness. There was also noted amastia, scarcity of hair and fat on the anterior chest wall and axilla. Some flattening of the left chest wall, but to a lesser degree than the right, was also present.

What is your diagnosis?

(continued on page 330)

ing it in a manner that would provide her with an unselfish motivation to take better care of her own health? She could be made aware that her health is of vital importance to her family, not only because of their love for her but also because of their great need of her and that in neglecting her own health she not only is doing an injustice to herself but to her family as well. Reminding her also that the small amount of expenses involved in having routine cancer checkups is microscopic compared to the tremendous amounts needed in the treatment of any advanced cancer.

This powerful maternal instinct has not been utilized heretofore in urging women to have annual cancer checkups. It could be used by the profession, The American Cancer Society, radio, television and the press by their directing their appeal not only to

the women themselves but to the families of these women. These families should be urged to assist in the ever present crusade to eradicate cancer. They should insist that any adult female member of their family have periodic checkups not only for their own protection but for the protection and need of the family. The woman who neglects her periodic checkups may not live to raise the family she has borne.

Inasmuch as this maternal instinct is such a dominating force in a woman's life and because she is so vitally concerned with the needs of her family, she will take better care of her physical health if this same instinct is used to make her aware of how vitally important she is to her family, thereby providing her with a motivating force that would cause her to present herself voluntarily for annual cancer checkups.

CARBON MONOXIDE POISONING

Max Klinghoffer, M.D./elmhurst

PURPOSE OF THIS PAPER is to discuss chronic carbon monoxide intoxication in a family, and to reiterate the problem in differential diagnosis of this type of intoxication. It is not our purpose to discuss in detail the diagnosis and treatment of ordinary carbon monoxide poisoning, since this is well documented.

Among the common sources of carbon monoxide in and about the home are the following: the exhaust gases of automobiles and other gasoline engines, which often yield 6 to 7 percent carbon monoxide gas in the exhaust. This can become dangerously high in a very short time in an enclosed space such as a garage. A second source is the hot water heater in the home if the venting system or various connections are faulty. Another common source of carbon monoxide is in the heating plant of a home where any type of combustible fuel is used. It should be emphasized here that natural gas contains no carbon monoxide whereas manufactured gas contains substantial amounts of carbon monoxide. However, both of these gases—natural and manufactured—may produce large amounts of carbon monoxide as a result of their combustion. Therefore, if the heating system is defective, substantial amounts of carbon monoxide may be released into the atmo-

sphere of the home. In the case of manufactured gas, ordinary leaks in the pipeline, regardless of combustion, may also be dangerous.

A concentration of carbon monoxide in the atmosphere of .01 percent is sometimes considered the maximum safe level. Concentrations of .02 percent and higher have been shown to produce toxic effects. At a concentration of .05 percent or higher of carbon monoxide in the air definite symptoms of intoxication will result. Because of the marked affinity of carbon monoxide for the hemoglobin (carbon monoxide has approximately 300 times as great an affinity for hemoglobin as does oxygen), even small amounts of carbon monoxide in the atmosphere will ultimately result in a large amount of carbon monoxide combined with hemoglobin in the blood. On this basis, even small amounts of carbon monoxide leaking from a heating system or other source may result in symptoms of this poisoning.

A man aged 45 was seen in the office, late in April, complaining of marked depression, inability to concentrate, and extreme fatigue. These symptoms had been present for at least three weeks. However, there had been a lesser degree of these same symptoms for perhaps six months. At the

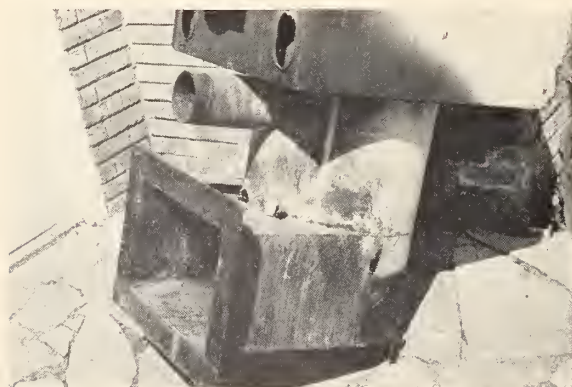


FIGURE 1—View of the combustion chamber of the furnace.



FIGURE 2—Close-up of combustion chamber, showing defect through which toxic gases escape to duct system.

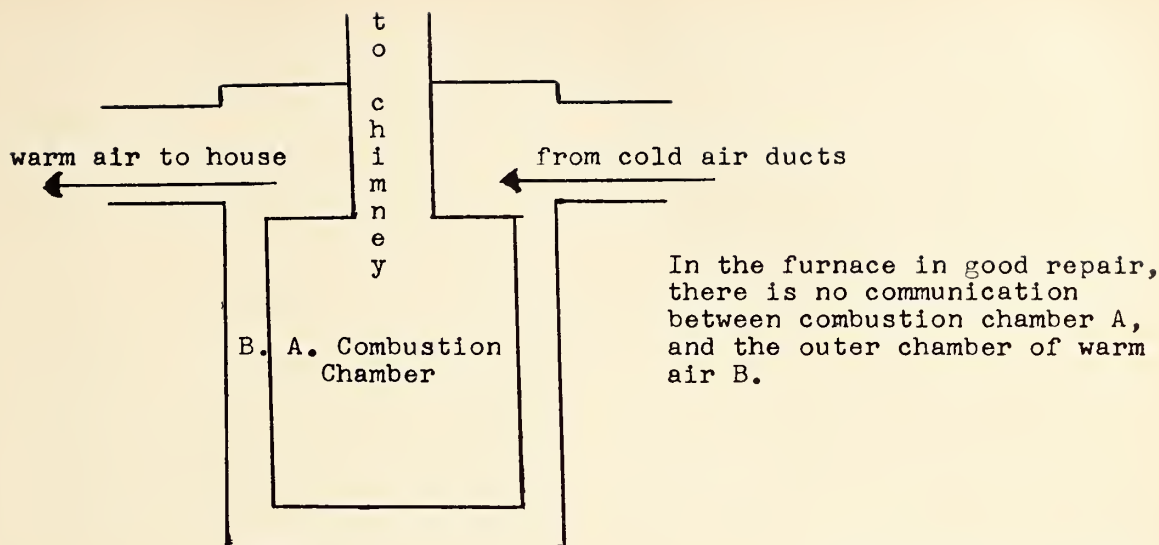


FIGURE 3—Furnace in good repair.

same time, a 16 year old daughter of this patient was seen with similar complaints including the extreme fatigue, but also involving episodes of syncope. Examination of the father revealed no serious physical abnormalities. However, there was some infection of the pharyngeal and nasal mucosa, with edema of the pharyngeal mucosa.

The 16 year old daughter demonstrated these same findings and she also had fairly marked dilatation of the pupils. The tentative diagnosis was that of a low grade viral infection of long duration with resultant fatigue and depression. The patients were both given antibiotics and antihistamines and were told to report back in two days. Two days later the evidence of respiratory infection had disappeared in both patients; both, however, stated that they "felt much worse." There was still dilatation of the pupils in the 16 year old girl.

Further questioning of the father revealed that there are nine members in the family. The wife, also age 45, had been extremely fatigued through the entire winter and had complained of marked irritability and headache. Two boys in the family aged 14 and 17, had been sleeping in a portion of the house which had a separate heating system by means of a space heater operated by gas. These two boys demonstrated no symptoms except irritability for several

months. A 12 year old son, who slept in the main part of the house, also had no symptoms except irritability and headaches. A seven year old son complained of no symptoms except headaches. A 10 year old girl had complained of extreme fatigue and headaches throughout the entire winter. A four year old son had been extremely drowsy and had been sleeping for long periods of time throughout the winter. All of the family emphasized rather frequent headaches which were generalized. A hemoglobin determination on the 45 year old man and the 16 year old girl taken at the second visit was normal. The father had a sedimentation rate of 40mm. in one hour. The daughter had a sedimentation rate of 48mm. in one hour.

On the basis of this family history a possible chronic intoxication by ingestion or inhalation was considered. A representative of the gas company was notified and immediately made a check of the heating system and other factors which might have resulted in release of carbon monoxide into the atmosphere of the home. Upon inspection, this representative was unable to visualize any major defect in the heating plant. But when a "smoke bomb" was placed in the combustion chamber of the furnace, smoke was detected in all of the rooms of the house.

By this time, the 16 year old girl was

suffering from syncope and vertigo, and she was hospitalized on that date. She now had a somewhat ashen gray color. This patient was hospitalized and placed in an oxygen tent where most of her symptoms disappeared within 12 hours. In spite of this marked improvement, the patient still exhibited signs of vertigo, syncope, and fatigue several days later.

Upon discovery of an apparent leak from the combustion chamber of the furnace into the circulating system of the ducts, the heating equipment was closed down. Upon removal of the central portion of the heating system by dismantling the furnace, it was found that there was a series of large breaks in the combustion chamber communicating directly with the duct system of the heating plant. These defects in the combustion chamber are demonstrated in the accompanying photographs.

Within one day after the heating plant had been shut down, the entire family noted a marked improvement in the condition of all members.

The mechanism of the leakage of the products of combustion, including carbon monoxide, into the duct system of the heating plant, are probably at least two. At the time of combustion and during the burning of the gas used in the furnace, it is likely that the positive pressure due to the expansion of gases would force some of the

products of combustion directly into the heating duct system. It also seems likely that when the blower system was operating, a venturi effect would take place, with relative negative pressure drawing the products of combustion into the duct work. These mechanisms are illustrated in the accompanying drawings.

Summary

A series of cases of chronic carbon monoxide intoxication in an entire family is presented. Since the symptoms of chronic monoxide poisoning are rather vague, these may easily be confused with the symptoms of chronic low grade infections, anemia, and various other ailments. The diagnosis of carbon monoxide intoxication should be considered where such symptoms are presented.

The difficulty in arriving at such a diagnosis is complicated by the fact that the defects in a heating plant may not be readily visible. It is obvious that inspections of such heating plants should be more than merely visual examination of the combustion chamber. Various methods of detecting carbon monoxide in the atmosphere should also be utilized and methods such as the use of the "smoke bomb," by qualified personnel, should also help to demonstrate communication between the combustion chamber and the duct system.

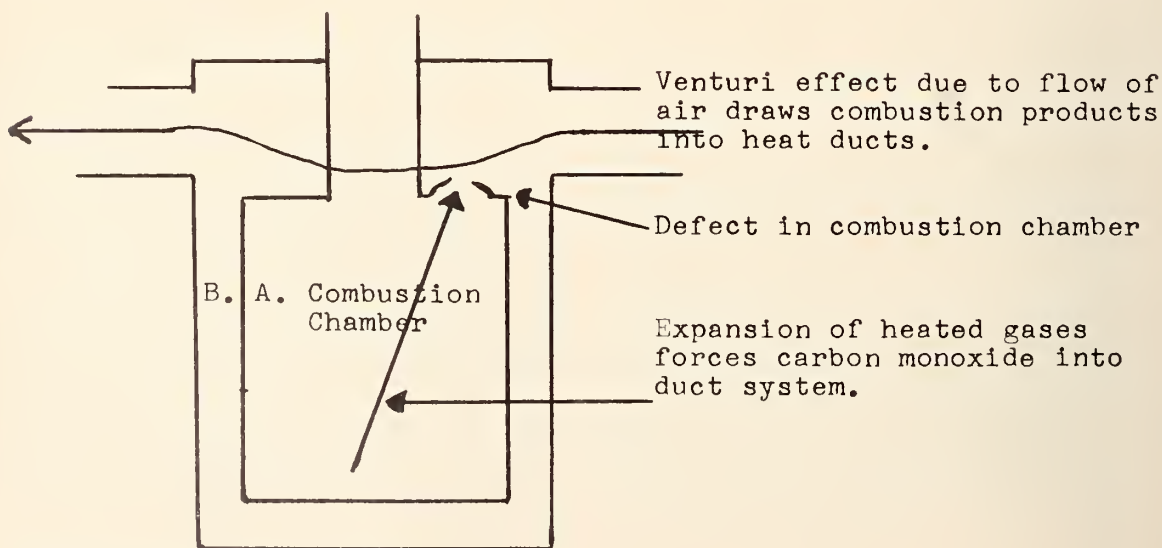


FIGURE 4—Defect in combustion chamber.

'ESTERGEL' - A NEW TOPICAL VEHICLE

Leonard D. Grayson, M.D. and Hilliard M. Shair, M.D.

THERE ARE MANY VARIETIES of corticosteroid and antibiotic preparations available to the physician. These include creams, ointments, lotions, liquids, and powders. Thus, it becomes necessary to select a vehicle for a formulation best suited for the needs of the patient.¹ This selection becomes even more important since medicaments are absorbed through the skin at different rates and with variable therapeutic efficiency.²

TABLE 1
Dexamethasone—'ESTERGEL'

	No. Cases	Excellent	Good	Fair	Poor
Atopic dermatitis	5	2	3	---	---
Hand eczema	2	---	2	---	---
Stasis eczema	2	---	2	---	---
Lichen simplex chronicus	2	2	---	---	---
Nummular eczema	1	---	1	---	---
Contact dermatitis	1	1	---	---	---
Psoriasis	1	---	---	---	1
Eczema (undetermined type)	1	---	1	---	---
Total	15	5	9	---	1

The adage of using lotions and compresses on acute areas, creams on subacute situations, and ointments on chronic conditions³ does not necessarily hold true when dealing with corticosteroids and antibiotics. However, a more suitable vehicle will certainly enhance the effectiveness of the preparation used.

Olansky⁴ has stated that the ideal vehicle

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must fulfill certain criteria. It should be one that will enhance physical release and promote dermal penetration of the compound employed. It should be non-irritating, non-sensitizing, non-drying, and non-toxic. The base should be odorless, non-staining, non-sticky, and leave a minimum of resi-

TABLE 2
Dexamethasone—Neomycin—'ESTERGEL'

	No. Cases	Excellent	Good	Fair	Poor
Intertrigo	3	---	1	2	---
Atopic dermatitis	2	---	1	---	1
Hand eczema	1	---	1	---	---
Stasis eczema	1	---	1	---	---
Lichen simplex chronicus	1	---	1	---	---
Total	8	---	5	2	1

due on the epidermis following topical application. It should be anhydrous, though water absorbing and compatible with a large variety of topical formulations.

'Estergel'* seems to fulfill most of these criteria. It is not a wax, ointment or cream but a gel containing isopropyl myristate, a higher alcohol, and microcrystalline waxes. Basic chemical studies⁵ have evaluated the *in vitro* moisture occlusive properties of various topical vehicles and Saran Wrap. This study⁶ showed that "0.5mm. barriers of 'Estergel' and petrolatum were about equivalent in their occlusiveness to Saran Wrap with a thickness of only 0.01 mm.

*Supplied through the courtesy of Dr. Lyon P. Strean, Merck Sharp and Dohme Research Laboratories, West Point, Pennsylvania.

Creams such as Fluocinolone, Methyprednisolone, and Flurandrenolone had very poor occlusive properties. The amount of moisture passing through these creams for an equivalent time period was far greater than for 'Estergel,' petrolatum, or Saran Wrap."

In an exhibit presented at the 1963 meeting of the American Academy of Dermatology in Chicago, the authors showed the absence of irritation, allergic response, or toxicity when 'Estergel' base was used in one group of 200 humans. Preclinical ani-

TABLE 3
Dexamethasone—Neomycin—
Etruscomycin—'ESTERTEL'

	No. Cases	Excel- lent	Good	Fair	Poor
Diaper rash	3	1	1	1	---
Intertrigo	2	1	---	1	---
Paronychia	2	1	1	---	---
Balanitis	1	1	---	---	---
Baker's eczema	1	1	---	---	---
Eczema (unde- termined type)	1	---	---	1	---
Atopic dermatitis	1	1	---	---	---
Total	11	6	2	3	---

mal experimentation⁵ has shown no primary irritation or toxicity.

With this information at hand we attempted to evaluate in a small group of patients the clinical effectiveness of various medications in the 'Estergel' base. No attempt was made to compare this with any other medicament or vehicle.

Dexamethasone (0.1%) in 'Estergel' was used on fifteen patients (Table 1) with a variety of skin disorders. Ninety-three per cent had good or excellent results.

Dexamethasone (0.1%) and Neomycin (0.5%) in 'Estergel' were employed on eight patients with a sixty-two per cent good response (Table 2).

Dexamethasone (0.1%), Neomycin

TABLE 4
Dexamethasone—Neomycin—
Nystatin—'ESTERTEL'

	No. Cases	Excel- lent	Good	Fair	Poor
Atopic dermatitis	8	3	3	1	1
Nummular eczema	3	3	---	---	---
Moniliasis	2	1	1	---	---
Eczema (unde- termined type)	2	1	1	---	---
X-Ray dermatitis	1	---	1	---	---
Contact dermatitis	1	---	1	---	---
Hand eczema	1	1	---	---	---
Pruritus ani	1	1	---	---	---
Lichen simplex chronicus	1	---	1	---	---
Genito-anal psoriasis	1	1	---	---	---
Pustular psoriasis	1	---	---	1	---
Infected Barber's interdigital cysts	1	1	---	---	---
Total	23	12	8	2	1

(0.5%), and Etruscomycin (0.4%) in 'Estergel' were used by eleven patients with various cutaneous disorders (Table 3). Seventy-two per cent responded.

Dexamethasone (0.1%), Neomycin (0.5%), and Nystatin (100,000 U/Gm.) in 'Estergel' were used on twenty-three patients with good or excellent results in eighty-seven per cent (Table 4).

Summary

A total of fifty-seven patients were treated with Dexamethasone (0.1%) alone or with antibacterial and antimonilial agents in the 'Estergel' base. Eighty-two per cent of these patients showed good or excellent responses to the medications. No patient revealed any evidence of intolerance.

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**See page 345 for special United Air Lines rates to
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THE LIVER AND INFECTIOUS MONONUCLEOSIS

AN ANALYSIS OF 348 CASES

Ralph J. Langsjoen, M.D./urbana

DESCRPTION of the "typical mononucleosis patient" has remained undisturbed for over a decade. One popular and highly regarded textbook of medicine states in its 1951 edition: "The diagnosis of infectious mononucleosis is not difficult in the typical case with lymphadenopathy, splenomegaly, lymphocytosis, and positive sheep cell agglutination."¹ An identical sentence is found 10 years and two editions later.² A scan of one dozen more recent textbooks reveals an increased awareness of the high incidence of laboratory hepatitis, yet all remain in essential agreement with this picture of "typical mononucleosis."

My own typical mononucleosis patient differs somewhat from this concept. Therefore a review of clinical records and laboratory data of patients with this disease who were cared for at McKinley Hospital over the past four years seemed a worthwhile undertaking. All but three of 435 such patients were University of Illinois graduate or undergraduate students.

Methods

Inasmuch as one suspected deviation from the stereotyped description above involved the frequency of clinical as well as laboratory hepatitis relative to splenomegaly, "neutral" criteria of diagnosis were employed.

Cases were therefore selected which showed either or both of the following:

- (1) A heterophile agglutination titer of 1/320 or higher.
- (2) At least one blood smear with over 50% lymphocytes, of which 20% or more were atypical cells.

Thus, 435 hospital records were examined, 87 of which showed neither criterion, leaving 348 cases believed to be diagnostically secure as a basis for this study. Final heterophile determinations were done in every case by the Illinois State Laboratory at Springfield, which considers a titer of 1/320 following differential absorption with

guinea pig kidney as diagnostic. Liver function tests were performed by the McKinley Hospital laboratory staff.

Clinical hepatitis was considered present whenever jaundice, a tender palpable liver, or distinct right upper quadrant tenderness to abdominal examination was recorded on the patient's hospital record. Clinical splenomegaly was considered present whenever a palpable spleen (tender or non-tender) or distinct left upper quadrant tenderness was recorded. Laboratory evidence of hepatitis was considered present when one or more liver function tests were abnormal in a patient.

The liver function tests employed, in order of frequency with which they were performed were as follows:

1. SGPT
2. Total Serum Bilirubin
3. Cephalin Flocculation
4. SGOT
5. Thymol Turbidity
6. Urine Bile or Urobilinogen
7. Alkaline Phosphatase
8. Prothrombin Time
9. BSP

A 3+ or 4+ cephalin flocculation test at either the 24-hour or 48-hour reading was considered necessary before this particular test was considered abnormal inasmuch as a 1+ or 2+ reading is sometimes obtained at this institution in diseases not considered hepatic in nature.

Tabulation of Results

The common denominator for all figures and percentages in the following material, with the exception of tabulation F, is 348, the number of patients comprising the survey. The terms clinical hepatitis, clinical splenomegaly, and laboratory hepatitis have been defined under "METHODS."

1960-64

A. Age and Sex—Patients	Student Population
Age range 17-43 years	16-64 years
Mean age 20	20
Sex ratio 53% Males	70.5% Males
47% Females	29.5% Females

University of Illinois Health Service, Urbana.

B. Liver vs. Spleen in Physical Diagnosis:	
Clinical Hepatitis	115 (33%)
Clinical Splenomegaly	103 (30%)
C. Heterophile Data:	
Diagnostic heterophiles	
(1/320 or more)	151 (43%)
Elevated but non-diagnostic	
heterophiles	68 (20%)
Negative heterophiles	94 (27%)
Heterophile not done during	
hospitalization	35 (10%)
	<u>348 (100.0%)</u>
D. Liver Function Test Data:	
One or more abnormal tests.....	179 (51.5%)
All tests normal (9 had	
clinical hepatitis)	19 (5.5%)
None performed	150 (43.0%)
	<u>348 (100.0%)</u>
E. Frequency of Clinical or Laboratory	
Hepatitis vs. Splenomegaly and	
Diagnostic Heterophile:	
Clinical or Laboratory Hepatitis	
(or both) recorded	203 (60%)
Splenomegaly or Diagnostic	
Heterophile (or both)	
recorded	203 (60%)
F. Liver vs. Spleen in Diagnostic	
Heterophile Subgroup (151 cases):	
Clinical Hepatitis	56 (37%)
Clinical Splenomegaly	55 (36%)
Clinical and/or Laboratory	
Hepatitis	96 (64%)

Discussion

Physically diagnostic hepatitis is just as much a part of infectious mononucleosis in this survey as splenomegaly. The survey also indicates that a deranged liver function test is a considerably more frequent finding than is a diagnostic heterophile titer. The latter term should perhaps be routinely employed with quotation marks—"diagnostic heterophile"—since the non-specificity of the heterophile test has been demonstrated³ and unnecessary confusion could thereby be avoided.

When one considers that of the 198 patients in which a liver function test was done, 179 resulted in abnormal values and 9 of the 19 others had clinical hepatitis despite absence of laboratory confirmation, it becomes apparent that combining a clinical and laboratory search for hepatitis in the patient with mononucleosis will, on the basis of this four-year survey, yield evidence of hepatitis in 19 out of 20 patients.

Most of the liver function tests which

were normal represented a single laboratory test, some of which were in the high normal range, and it seems likely that if one examines the mononucleosis patient for hepatitis with the same awareness and diligence with which one traditionally examines for splenomegaly or positive heterophile titer when "glandular fever" is evident, the absence of hepatitis in mononucleosis approaches zero.

The separate breakdown of the diagnostic heterophile sub-group indicates that no significant alteration of clinical and/or laboratory hepatitis frequency relative to splenomegaly occurs in the survey whether one uses a high heterophile titer population or a low, negative, or absent heterophile population.

A much smaller group of infectious hepatitis patients treated between 1960 and 1964 has likewise been reviewed. Findings will not be itemized in this paper other than to mention that approximately 25% of them meet the criteria for diagnosis upon which this survey of mononucleosis patients is structured.

Projection

There would appear to be some justification in considering the possibility that mononucleosis and hepatitis are the same disease, i.e., caused by the same etiological agent. The suggestion will be immediately labeled gross speculation. This is as it should be. In the world of "lumpers" and "splitters," this may be too large a lump for the splitter or even the conservative lumper to swallow. There is, after all, no proof that the same agent causes a condition which in one form we term mononucleosis, and in a more severe form we term hepatitis. The agent causing mononucleosis has not been identified and the agent causing hepatitis not successfully isolated, it will be pointed out.

There is a corollary to this objection, however, which is worth bringing into focus. As long as the exact identity of the agent or agents responsible for the two conditions remains unknown, the description of two separate disease entities in our clinical textbooks is likewise a speculation. Put another way, in mononucleosis (or hepa-

titis), we may be dealing with a "splitters' disease."

Following are some points which support this projection:

1. The size of the infectious hepatitis virus is not known, but virus particles measuring 10 to 20 $m\mu$ in diameter have been found in cell cultures and liver biopsy specimens taken from human volunteers ill with hepatitis.⁴ Likewise, electron microscopy studies have revealed numerous virus-like particles, 15-20 $m\mu$ in size in culture containing serum from mononucleosis patients.⁵

2. The histopathology of the liver in mononucleosis is generally not so severe as that in infectious hepatitis, but there are occasional reports of liver biopsies in which hepato-cellular necrosis in mononucleosis is indistinguishable from that of infectious hepatitis.^{6, 7} This difference in histopathology conceivably parallels the spectrum which has at one end the mild case of mononucleosis and at the opposite end, the severe case of infectious hepatitis, finer shades of yellow comprising the middle region.

3. The incubation period of mononucleosis was once considered to be shorter than that of infectious hepatitis,⁸ but when the various incubation periods suspected in individual studies of these two diseases are amalgamated, it appears that a period as long as 49 days is possible in each instance.

4. The response of both conditions to the therapeutic use of steroids^{9, 10} and the tendency of both to linger or worsen without an adequate restful convalescence are similar.

5. The anorexia, the nausea, the posterior cervical lymphadenopathy, the atypical lymphocytes, the positive heterophile titer sometimes noted in infectious hepatitis,¹¹ the initial leukopenia in both conditions, the headache, the lassitude, even the complications (e.g. lymphocytic meningitis), are quite similar.

6. The age predilection of both conditions is one of childhood and young adulthood, large numbers of subclinical cases being suspected in both conditions.

7. Recent work on a specific antibody test

for infectious hepatitis seemingly cannot differentiate infectious hepatitis serum from that of infectious mononucleosis.¹²

8. A recent laboratory accident suggests that the condition of host cells may determine whether infection occurs with hepatitis or mononucleosis serum, overlap being rarely evident.⁵

9. Serum enzyme profiles in the two conditions are apparently quite similar.¹³

Summary

Data have been collected and presented on 348 cases of mononucleosis seen at McKinley Hospital between 1960 and 1964 which indicate that physically diagnoseable hepatitis is at least as frequent a finding as splenomegaly in this disease. The same data indicate that abnormal liver function tests are found with considerably greater frequency than diagnostic heterophile titers. It is therefore suggested that these two parameters become incorporated sometime soon into textbook descriptions of "typical infectious mononucleosis."

Physical examination supplemented by one or more liver function tests showed evidence of hepatitis in 95% of patients.

A speculation has been indulged in concerning the possibility that mononucleosis and infectious hepatitis represent different grades of severity of the same disease process.

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MALINGERING

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THE FREQUENCY WITH WHICH the question arises as to malingering, especially in medical-legal problems and in the differential diagnosis from the neuroses, suggested the need for a review of the concept of fraudulent illness.

Feigned illness or its opposite, attempts to consciously disguise illness, are not usually considered significant in medical practice. Conscious and deliberate symptom production is usually seen as related to circumstances in which the use of illness is productive of gains obtained more easily through illness or medical channels than through other means.

Expressions of malingering may be divided into the following categories:

1. Pure malingering—deliberate deception by describing and producing non-existent symptoms or the opposite deception in which symptoms are concealed deliberately should be included here.

2. Partial malingering involves exaggeration of symptoms of a real disease consciously and voluntarily.

3. False imputation is the ascribing of definite symptoms to a cause consciously recognized to have no relationship to the symptoms, i.e., a person with pain due to a slipped intervertebral disc places the cause of pain on a recent accident.

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Circumstances particularly conducive to malingering are induction into military or military service, avoidance of school, job, or other similar responsibilities, seeking admission to hospitals and similar facilities. In general the circumstances for encouraging malingering are avoidance of distasteful, painful, frustrating or boring situations or for gaining some preferred position, or unwarranted compensation.

There is a close correlation between malingering and personality. A rather weak sense of social and group responsibility is a personality trait of those who use malingering for gaining some preferred position, e.g., compensation for injury, avoidance of a responsible task, etc. Inadequate, asocial and immature persons may malingering to avoid military service, to gain a dependent position or to avoid that which is unpleasant. Often one finds a tendency toward delinquency or other acting out tendencies in the earlier life history. Previous law suits or difficulties with law enforcement agencies or a history of excessive lying may give diagnostic clues. Patients with anxiety over having to face certain situations ordinarily avoided, and those with unusual rituals which they would find embarrassing to disclose, e.g., a wide variety of bowel and bladder disturbances of an embarrassing nature, might lead the person to volitionally attempt to create symptoms of illness; sexually perverse persons may find fraudulent illness a means of escape from revealing the sexual difficulty and at the same time escape from unpleasant situations. It can safely be stated that malingering is usually evidence of considerable psychopathology.

Characteristic symptoms of malingering are: the lack of real sincerity, the incongruity and lack of completeness of the symptoms. An exaggerated character to the symptoms in which there is a quality of attempting to establish the validity of the symptoms or complaint is present. The hysterical patient in whom unconscious factors for symptom formation as distinguished from the conscious and volitional effort of the malingerer is more likely to

give the impression that the symptoms are to be taken for granted and if the examiner doesn't recognize their validity or understand them, it's his shortcoming. The symptoms are not only odd and bizarre as they may be in conversion hysteria, but tend to lack constancy. They are more likely to respond to trickery which will demonstrate the fraud, e.g., "How high were you able to lift your arm before it was paralyzed?" The patient then raises his arm above his head. The malingerer tends to be careless about his symptoms and may readily give them up when he feels he is not being watched. A hysterical tremor may be sustained for periods much longer than is possible for a person who attempts to demonstrate such a tremor voluntarily. The malingerer finds it difficult to sustain a symptom. Symptoms described as distinguishing the malingerer from the hysteric are suspicion of examination, being careful in choice of words to avoid detection; sullen, resentful, uncooperative behavior; greed, dishonesty and a demanding attitude and are particularly applicable to the industrial accident case. Symptoms produced by the malingerer may involve almost any organ of the body. Amnesia, confusion, orientation difficulty with seeming perplexity; psychotic symptoms; blindness, hearing difficulty, speech distortions of all kinds, smell and taste loss; paralysis; partial or complete loss of sphincter control; sensory loss, pain; dysfunction of internal organs. The limitations are determined by knowledge of symptoms and organs, the acceptability of the symptoms and the response expected from those who are to be influenced by the symptoms.

It should be remembered that there is no sharp line between that which is conscious and that which is unconscious. An awareness of a desire to simulate can be seen in the hysterical patient and varying degrees of unconscious elements in the behavior of the malingerer. The more the conscious elements in the clinical picture the more is the condition to be considered malingering. The more the unconscious elements predominate the more one considers the clinical picture as related to hysteria.

The conscious denial of illness is a form of malingering which has less significance than the denial of illness in which primarily unconscious forces are predominant. Rationalizations for symptoms or disability are accepted by the person as adequately explaining the dysfunction. Conscious efforts to deceive in order to avoid the unpleasant experience of loss of prestige or feeling of being unacceptable are seen in attempts to enter military service by epileptics or others having medical problems which would lead to their rejection. The feelings that illness is evidence of ineffectiveness and lack of masculinity, may create a desire to falsify or avoid describing symptoms. Some patients may purposely distort or not express the symptoms of what they fear is a dread disease; the utterance of the complaints is seen as causing trouble which is best avoided by not mentioning or hearing about it. The patient is hoping the examiner will confirm his need to deny that anything dreadful is happening.

Psychotherapeutic care may be offered to the patient. Such care may be required or desirable for reasons other than the needs of the patient, as is the case in the treatment of veterans or persons institutionalized for a variety of reasons. The therapist may alter the facade of pseudo-illness or disability by not commenting or responding to that part of the patient's behavior, but by responding positively and on the highest level of verbal and behavioral communication to aspects of the relationship which suggest that the patient is contacting the therapist on a more mature level (selective attention and selective inattention). For instance, one is non-responsive to muttered regressed language (baby talk), but does respond to the more freely uttered adult language of the patient. The therapist continually maintains a mature attitude toward the patient's behavior, attitudes, verbalizations, and attempts to exploit the interpersonal relationships so as to encourage the patient to give up patterns of infantilism for more adult functioning.

A CLINICAL STUDY OF FECAL pH IN PEDIATRIC CONSTIPATION

O. W. Crawford, M.D., F.A.A.P., and
N. O. Calloway, M.D., Ph.D., F.A.C.P.

CLINICAL STUDIES OF CONSTIPATION in infants and children indicate that an investigation of the fecal pH in these cases might be of interest. The fecal pH of the breast-fed infant is acid (pH 4.7-5.1) and the predominant bacteria are the gram-positive bacilli of the lactobacillus group.¹

"There is a striking difference between the character of the fecal flora of the breast-fed and that of the artificially fed infant, and it has been suggested that this may have a bearing on the relative freedom from gastrointestinal upsets in breast-fed babies."²

"An infant is rarely, if ever, constipated on an exclusively breast milk diet."³ It is well known that constipation frequently occurs during transition periods of feeding, from breast to formula and later to a more solid diet. Further, it has been determined that in the artificially fed infant "A formula high in sugar and low in milk is laxative; the reverse proportion tends to be constipating . . . [and] . . . the lower intestinal content is alkaline in reaction."⁴

Therefore, a diet which is high in protein and calcium content, as for example whole cow's milk, results in an alkaline stool which tends to be hard, dry and is inclined to produce a condition of sluggishness and constipation.⁵ Thus, when gram-negative organisms are promoted, the fecal pH approaches 7,⁶ and the end products of protein decomposition or putrefaction are constipating.^{7,8} Conversely, when gram-positive organisms such as lactobacilli are increased, the fecal pH approaches 5. The growth of the lactobacillus group is stimulated by sugars which act as a culture medium. Not

only do the products of sugar breakdown stimulate peristalsis but the sugar spares the decomposition of protein and, therefore, minimizes the formation of the constipating end products of protein decomposition.⁷

Clinical investigation of chronically constipated adults has indicated that a relationship between fecal pH and hard, dry stools might exist. Also, patients who have been relieved of their pruritus ani by correction of the fecal pH from neutral or alkaline to 6 or 5 were simultaneously relieved of their constipation and the stools with a pH of 7 to 9 were deficient in lactobacillus—the correlation being about 94 per cent. These facts made it seem worthwhile to determine the fecal pH in a group of constipated infants and children and to observe any change which might occur by correction of the constipation by diet modification. It is well known that the influence exerted by diet upon the flora of the large intestine may be of value in treatment.⁵

The addition of Maltsupex®* (a nutritive food concentrate derived from the natural enzymatic digestion of barley) as a diet modifier and to relieve the constipation was thought desirable for the following reasons:

- (1). It has a record of efficacy with safety in the treatment of infant and adult constipation and pruritus ani.¹⁰⁻¹⁸ Also, a frequent reason for constipation and pain in infants is rectal fissure and this preparation has been very useful in correcting the constipation.¹⁹
- (2). It has a high proportion of maltose, and corrects a lactobacillus deficiency by acting as a culture medium to stimulate the rapid growth of any lactobacillus strains normally present in

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*Borcherdt Company, Chicago, Illinois.

an individual's gastrointestinal tract.¹⁰⁻¹¹ "As the lactobacillus flora is gradually restored to normal abundance, pruritus ani gradually subsides, bowel movements become regular and of natural consistency. The fecal pH declines from 9 or 7 to a normal 6 or 5. A laxative effect of the powder becomes apparent as pH6 is approached indicating a reduction of dosage."¹⁰

(3). Studies indicate that a high ratio of sugars to calcium retards its precipitation in the intestinal lumen and results in better absorption of calcium.²⁰

Methods and Material

This investigation included 25 constipated infants and children ranging in age from 3 months to 4 years. Other than being constipated, these patients were in good health. Nitrazine and pHDrion papers† were used to determine the fecal pH. The former has a range of 4 to 7.5, the latter shows the range between 4 and 9. The color produced on the test paper when moistened by the fecal material indicates the pH. The first tissue wipe following defecation is used to smear the test paper. Excess fecal matter is wiped off and sufficient moisture is present to change the color of the paper. This change is compared with the color chart and a pH determination made. The nurse or mother was instructed not to moisten the test paper with water before smearing with fecal matter. In order to obtain accurate readings, patients were selected whose mothers were nurses, physicians' wives, or with similar background. After the initial fecal pH was taken, each patient was placed on a Maltsupex regimen for an average of five days and the stool pH was determined after each bowel movement. One or two tablespoonfuls of the liquid or powder were added to the day's formula. Older infants and children received two tablespoonfuls once or twice a day in milk or by spoon—heaping measures of the powder were used.

†Nitrazine, E. R. Squibb & Sons, New York, N.Y.; pHDrion,® Micro Essential Laboratory, Brooklyn 10, N.Y.

TABLE
EFFECT OF MALTSUPEX THERAPY
ON FECAL PH IN PEDIATRIC
CONSTIPATION

Patient	Age	Before Therapy pH of Stool	After Therapy pH of Stool
A. D.	6 mo.	7.0	6.0
O. C.	9 mo.	7.5	6.0
J. T.	36 mo.	7.0	6.0
W. M.	48 mo.	7.5	6.0
W. W.	12 mo.	7.0	6.0
J. J.	18 mo.	7.5	6.5
S. W.	11 mo.	7.0	6.0
S. T. J.	10 mo.	8.0	6.0
N. C. J.	24 mo.	7.0	6.0
T. T.	8 mo.	7.5	5.0
W. M. W.	24 mo.	7.0	5.0
M. W.	27 mo.	7.0	6.0
D. S.	7 mo.	7.0	5.0
S. J.	8 mo.	7.0	5.0
P. R.	9 mo.	8.0	6.0
T. R.	26 mo.	7.0	6.0
J. S.	38 mo.	6.5	5.0
R. R.	22 mo.	6.5	5.0
W. T.	32 mo.	7.0	6.0
D. K.	19 mo.	8.0	6.0
J. M.	3 mo.	7.0	6.0
R. S.	5 mo.	7.0	6.0
C. T.	12 mo.	7.0	6.0
R. W.	36 mo.	7.0	5.0
O. T.	8 mo.	6.0	5.0

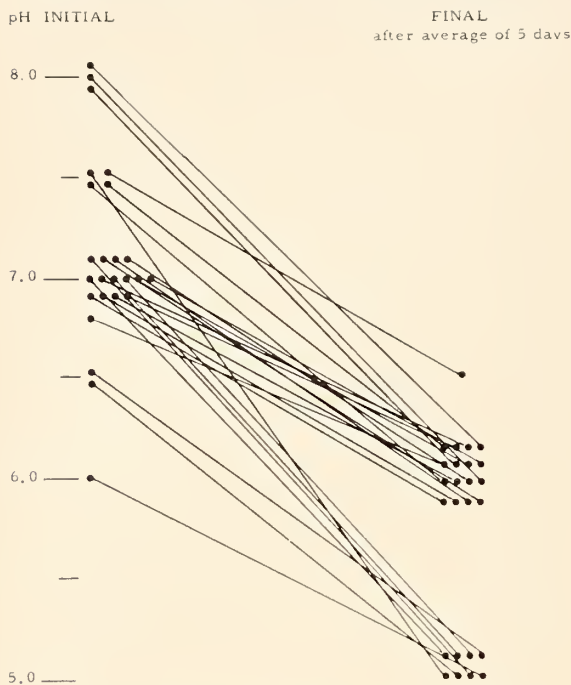
Average of five days between initial fecal pH and pH after treatment with Maltsupex.

Results and Discussion

Although our experience with Maltsupex and the findings of other clinical investigators have been excellent, the results in these cases merit special consideration. Not only did all patients have relief with soft stools of normal consistency within an average of five days, but no side effects were observed. Since complete safety is of such prime importance in this age group, the freedom from any untoward reactions such as bloatedness, cramping, diarrhea, etc., is noteworthy. The initial fecal pH averaged above 7 in these patients. Within an average of five days on therapy the stool pH showed a mean of 5.7 (Table and Chart). The smallest drop in pH was from 6.8 to 6, which occurred in one case. The greatest drop in pH occurred in three cases: 8 to 6 in two patients and 7 to 5 in one child. All cases except one (initial pH 7.5, final pH 6.5) had a final pH between 5 and 6.

In this age group, patients' acceptance of a product may be a problem. Maltsupex was

CHART DROP IN FECAL pH AFTER THERAPY



well liked since the powder readily dissolves in cold or warm water, milk, or other fluids. In milk it has a fine malted milk flavor. It also may be used on cereals because of its sweet taste. The effectiveness of this therapeutic approach probably is related to the several factors mentioned in the introduction: a fecal pH of 7 or over indicating a lactobacillus deficiency; a fecal pH of 5 to 6 indicating a normal lactobacillus flora; the effectiveness of the preparation in converting a gram-negative constipating putrefactive flora to a normal gram-positive lactobacillus flora with a pH approaching that of the breast-fed infant. Further, this preparation contains a high proportion of maltose and the products of sugar breakdown are laxative: the lower volatile fatty acids, lactic acid and CO_2 .⁷ Finally, studies indicate a high ratio of sugars to calcium results in better absorption of calcium by retarding the precipitation of its insoluble salts in the intestinal lumen.²⁰

Summary

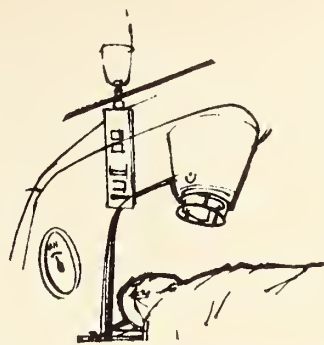
Twenty-five constipated pediatric patients between the ages of three months and

four years were treated with Maltsupex—a nutritive food concentrate derived from the natural enzymatic digestion of barley. In all cases soft stools of normal consistency occurred within an average of five days of therapy. No bloating, diarrhea, cramping, or other side effects were noted. An attempt was made to evaluate any possible correlation between fecal pH, relief of constipation, and the growth of the lactobacillus colonic flora. The initial fecal pH averaged above 7, indicating a deficiency of the lactobacillus flora. After an average of five days of treatment, the stool pH had decreased to a mean of 5.7, indicating a normal gram-positive lactobacillus flora approximating that of the breast-fed infant.

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Medical Progress



HARVEY KRAVITZ M.D./progress editor

ANTIBIOTICS IN 1965

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MODERN ANTIMICROBIAL THERAPY, which is predominantly dependent on antibiotics, is probably the most significant tool that accounts for the individual practitioner's contribution to the increased longevity and health of the public. In many other activities such as sanitation, nutrition, and even immunization, the physician's role is a shared one. In the individual management of patients not only have antibiotics made the direct treatment of major killers possible but they have also enhanced the ability to use surgery and intervene favorably in deliveries. Still there is evidence that in the daily confrontation between the practitioner and the problems resulting from the nature of the microbes is one between formidable adversaries. The fact that there are still requests for information and new

agents reflects the problem's existence plus the profession's constant concern with optimal employment of its resources. Implied is the need for continuous appraisal of what may be done in terms of maximum good with minimal harm. Operating within such narrow boundaries is at best difficult and does require a fresh look at the situation with due regard for the changes in the tools and increased understanding.

Antibiotics are so well established that there is little danger of minimizing their importance by emphasizing their deficiencies. In order to understand the latter, however, a short review of the current status of accepted use is essential.

In Table 1 are listed the organisms which are the most common causes of specifically treatable disease. Most of these are first encountered in the patient who is ill at home or in the office. These are the most common bacterial infections encountered and prior to the era of treatment accounted for much morbidity and were among the leading causes of death. To help under-

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TABLE 1

RECOMMENDED USE OF ANTIMICROBIAL AGENTS IN

Organism	Relative Frequency*	Problems Often Treated Out of the Hospital			
		Site Commonly Involved	Other Sites	Primary	Secondary
<i>Streptococcus</i> (gp A)	20-50	Throat	20%	Majority	Common
<i>Staphylococcus</i>	20-50	Skin**	< 5%	Majority	Common
<i>Pneumococcus</i>	5-10	Respiratory (Esp. lung)	5%	30%	70%
<i>Gonococcus</i>	2-5	Genitalia	< 5%	Majority	Rare
<i>Hemophilus Influenza</i>	0.5-1	Respiratory	10%	Rare	Majority
<i>Bordetella Pertussis</i>	< .05	Respiratory	.....	Majority	?
<i>Mycoplasma pneumonia</i>	1-2	Respiratory	.....	Majority	?
<i>Escherichia coli</i>	1-5	Urinary†	20%	Majority	Common
<i>Salmonella</i>	1	Intestine	10%	Majority	Rare
<i>Shigella</i>	0.5	Intestine	< 5%	Majority	Rare
Syphilis	< 0.1	Genitalia	> 50%	All	.....
<i>Fusospirochetal</i>	Unknown	Mouth + Throat	.....	Unknown	Unknown

* = Relative Frequency based on viral upper respiratory illness as 1000.

** = Skin commonly infected. Nasal Carriage more common.

† = When staphylococcal infections occur as hospital infections other more toxic and/or difficult to use drugs such as Vancomycin, Ristocetin and Kanamycin may be used.

stand the problems faced by the physician in his attempt to reach these patients the relative frequency is given in terms of the viral illnesses with which many may be confused. This figure is estimated from frequencies given in a variety of studies as well as our own experience in some community surveys.

The National Health Survey of 1962-1963 allows an estimate that about 200 million episodes of viral respiratory illness occurred. In the tables a base of 1000 for these viral respiratory infections was used. Certainly only a minority of episodes of illness among the total 400 million which occur each year would require antibiotics. As indicated, each organism is associated with a relatively characteristic site of involvement often with a typical picture but most of them may involve other tissues alone or in addition. To appreciate the dilemma of the practitioner it is necessary also to realize that while most of these organisms are capable of primary invasion they may also be found as etiologic in the complications of

many of the virus diseases.

Most of these primary pathogens represent the area of greatest success with antibacterial treatment, and in general they are quite susceptible to the action of several agents. In the table are listed agents of choice. By and large sensitivity tests are not needed with the organisms except for the staphylococci where a new penicillinase resistant penicillin might be needed or in *E. coli* pyelonephritis or Shigellosis where sulfonamides still appear to be adequate unless the strains are resistant. As may be seen, limited prophylactic programs have been carried out in certain populations or in particular types of patients for many of these organisms. The organisms in Table 1 represent the area of "triumph" both because of the relatively consistent good results but also because of the frequency of these infections.

In Table 2 are listed many of the organisms which cause infections serious enough to require hospitalization. It is more difficult to estimate the frequency of many of

PATIENTS WITH CONDITIONS OF KNOWN ETIOLOGY

Choice	Alternate	Treatment	
		New Alternate	Prophylaxis
Penicillin	Erythromycin Oleandomycin	Lincomycin	Limited
New Penicillin§	Erythromycin‡ Oleandomycin	Lincomycin Cephalothin	None
Penicillin	Tetracycline Erythromycin	Lincomycin	Limited
Penicillin	Tetracycline Streptomycin	Lincomycin	Limited
Tetracycline or Chloramphenicol	Ampicillin	Cephalothin	Limited
Tetracycline or Chloramphenicol	-----	-----	Limited
Tetracycline	-----	-----	None
Sulfonamide§	Many¶	Cephalothin Nalidixic Acid	Limited
Chloramphenicol or Ampicillin	-----	Cephalothin	None
Sulfonamide§	Many¶	Cephalothin	None
Tetracycline			
Penicillin	Tetracycline	-----	Limited
Penicillin	Tetracycline	-----	None

‡ = Urinary tract commonly infected. Bowel carriage essentially universal.
¶ = Chloramphenicol, Ampicillin or Kanamycin may at times be needed, particularly in hospital acquired E. coli infections.
§ = Bacterial Susceptibility tests may be of use.

these since the elucidation of their role in infections acquired in the hospital is still being developed. The others which are generally encountered in community patients are certainly less than 1/1000 as frequent as the reference incidence of viral respiratory disease. That these infections are more difficult to treat is easy to surmise from the recommendations for combination therapy and the use of laboratory aid in the selection of an agent likely to be successful. Also in these infections the more toxic agents may be needed.

If the physician generally could make a reasonable presumption about the etiology or withhold treatment until adequate bacteriologic examinations were finished there would be little difficulty in following the regimens suggested in Tables 1 and 2. Whenever possible it is indeed wise to await sound laboratory evidence since clinical diagnosis of etiology is at best an educated guess. Often overlooked is the great help which can be gotten by examination of stained smears of appropriate secretions.

In Table 3 the problem is approached from the point of view of syndromes as they are apt to be encountered. As indicated, upper respiratory infections make up the bulk of illness. A generous estimate is that 1/10 may be primarily bacterial or have some bacterial component but as indicated, unless there is otitis media, sinusitis or a lower respiratory tract complication, only the group A streptococcus is worthy of therapeutic effort. It is for this reason that modern simplified community throat culturing programs are based on the ascertainment of the presence or absence of beta hemolytic streptococci. It is important to note that in spite of the anxiety of the physician to treat before culture results are available in order to shorten the illness, well controlled studies indicate that such shortening is minimal in uncomplicated pharyngitis. The principal reasons for treatment are the prevention of pyogenic complications and of rheumatic fever. Each of these is readily accomplished after results of the culture are known. Since glomerulo-

TABLE 2

RECOMMENDED USE OF ANTIMICROBIAL AGENTS IN

Organisms	Significantly Acquired		Problems Often
	In Hospital	Out of Hospital	
Meningococcus		X	Penicillin with or without Sulfonamides
Non-gp A Streptococcus	X	X	Penicillin often with Streptomycin
Bacteroides	X	X	Tetracycline
Klebsiella-Aerobacter	X		**Chloramphenicol, Tetracycline, Kanamycin
Proteus mirabilis	X		Ampicillin; Large dose Penicillin
Other Proteus	X		**Chloramphenicol or Kanamycin
Pseudomonas	X	X	Polymyxin (Colistin)
Other "Coliforms"	X		**Chloramphenicol, Tetracycline, Kanamycin
Brucellosis		X	Tetracycline with Streptomycin
Tularemia		X	Streptomycin
Tuberculosis		X	Isoniazid plus one other
Rickettsial + Certain Viruses		X	Tetracycline
Fungus		X	Amphotericin

* = Doesn't include Staphylococcus, E. coli, Salmonella and others listed in table which are as frequently treated in the hospital as infections listed here since they are much more commonly treated in milder forms out of the hospital. All infections listed in this table are less than 1/1000 as common as Viral Upper Respiratory illnesses.

nephritis is difficult if not impossible to prevent in patients already symptomatic the best control measure when a nephritogenic strain is in the community is culture and treatment of contacts. As indicated, even in streptococcal disease there is no good evidence that treatment appreciably mitigates the course of uncomplicated infection and in addition, the other bacteria found on culture in the similarly uncomplicated patient have no demonstrable effect on the course whether treated or not. Three complications are important, however, and must be ruled in or out by physical examination. It is this need that makes the prescribing of antibacterial therapy over the phone without examination a major abuse. Unless one uses the opportunity to ascertain the presence of otitis, sinusitis or lower respiratory infection as a basis for rational therapeutics he is in fact denying any opportunity to do more than the patient can do for himself "over the counter." With otitis media, which varies in frequency as indicated by the age of the patient, the problem becomes more complex. Even in

these patients it is likely that only about 25% are bacterial infections.

This may account for the relatively poor results reported in some recent series. However, purulent rupture of the membrane and spread to the mastoid are much less frequent and probably represent the major gain from antibiotics. In spite of the several species which may be involved either penicillin or tetracycline appear to work well in over 95% of patients who have a bacterial etiology. Even though routine treatment of otitis media will be a fourfold over-treatment, it is hard to escape the need to begin treatment when this condition is diagnosed. Since the loss of hearing in carefully followed patients is considerably greater than generally realized, it is undoubtedly worth the expense to obtain definitive cultures in these patients. Acute sinusitis is another complication which may require treatment. Because of the fact that when the acute inflammation is lessened drainage often improves a relatively short course is often all that is needed unless streptococci are present. Of course appro-

PATIENTS WITH CONDITIONS OF KNOWN ETIOLOGY

Treated in the Hospital*

Alternatives	New Alternatives	Prophylaxis
Tetracycline; possibly Ampicillin	-----	Limited
Several less effective	-----	Limited
Penicillin	-----	None
**Streptomycin, Nitrofurantoin, Sulfonamides	Gentamicin, Nalidixic A Cephalothin	None
**Chloramphenicol, Kanamycin, Streptomycin, Nitrofurantoin, Sulfonamides	Cephalothin, Nalidixic A	None
**Streptomycin, Nitrofurantoin, Sulfonamides	Gentamicin, Nalidixic A	None
**Rarely effective	-----	None
**Polymyxin, Streptomycin, Nitrofurantoin, Sulfonamides	Gentamicin, Nalidixic A Cephalothin?	None
Chloramphenicol		None
Tetracycline, Chloramphenicol		None
Other combinations		Limited
Chloramphenicol		Limited
		None

** = Susceptibility tests may be useful.

priate procedures to establish drainage are needed if the response is not prompt. Lower respiratory infections with severe airway involvement, pneumonia or when superimposed on chronic bronchitis, should be treated according to the most likely etiology.

The need for treatment in patients with diarrhea and skin infections is determined primarily by the severity since complications are generally dependent on the primary process. When culture results cannot be awaited treatment may need to be initiated on the basis of the probable organisms involved.

Bacterial complications of the childhood communicable diseases are often manifested by respiratory or skin complication and should be managed by careful examination and treated when indicated as suggested for these conditions as above.

Most bacterial diseases develop characteristic localizations within a few hours to days of onset. In addition, patients in serious danger manifest evidence of critical illness quite rapidly. Consequently most fevers of unknown origin, i.e., fever without lo-

calizing symptoms or critical condition of short duration need not be treated. When the course lasts over a week more active diagnostic procedures are often needed.

While urinary tract infections are often treated on an ambulatory basis it should be emphasized that with quantitative techniques it is simple to get a meaningful urine culture before treatment and particularly important after it.

Difficulties in obtaining relatively non-contaminated specimens makes the diagnosis of etiology of pelvic infection in females unreliable. Many empiric regimens have therefore been developed. There appears to be a consensus that this is one area where the broad spectrum concept appears useful and the tetracyclines or chloramphenicol are often advised.

Purulent meningitis demands immediate treatment which usually may be based on the examination of a smear of the spinal fluid sediments. When the examination is negative an appropriate regimen can almost always be chosen on the basis of age, degree of illness and probable portal of entry. We

TABLE 3

CLINICAL DIAGNOSIS IN WHICH USE OF CHEMOTHERAPY IS A CONSIDERATION

Diagnosis	Relative Frequency*	Usually Encountered Bacteria which may be involved			Importance for Treatment
		Out of Hos-pital	In Hos-pital	Organism	
Upper Respiratory	1100	X		Streptococci gp A Staphylococci Pneumococci H. influenzae	Marked Unimportant Unimportant Unimportant
Otitis Media	10-100**	X		Streptococci gp A Pneumococci Staphylococci H. influenzae	Marked Marked Occasional Moderate
Sinusitis	? Relatively common	X		Staphylococci Streptococci gp A Pneumococci	Moderate Occasional Occasional
Lower Respiratory (Laryngotracheo-bronchitis)	? Relatively common	X		Pneumococci H. influenzae	Marked Marked
Pneumonia Primary	10-20	X		Pneumococci Mycoplasma	Marked Moderate
Secondary		X		Pneumococci H. influenzae Staphylococci Staphylococci Klebsiella	Marked Moderate Moderate Moderate Occasional
Secondary			X	Staphylococci Pneumococci "Coliforms"	Marked Moderate Moderate
Enteritis (diarrhea)	10-20	X		E. coli** Salmonellae Shigellae	Moderate Occasional Occasional
Cellulitis and related Skin Infections	5	X		Staphylococci Streptococci (gp A)	Marked Moderate
Cutaneous Ulcers	1-5	X		Staphylococci Anaerobes "Coliforms"	Marked Marked Moderate
"Childhood" Communicable Dis.	15-30	X		Pneumococci Streptococci (gpA) Staphylococci H. influenzae	Moderate Occasionally Occasionally Occasionally
Fever Unknown Origin less 1 wk.	20-40	X		"Normal Flora"	Unimportant
Fever Unknown Origin over 1 wk.	< 1	X		Tuberculosis Fungi Streptococcal endocarditis Other	Occasionally Occasionally Occasionally Occasionally
Urinary Tract Infections	1-2	X		E. coli Other Coliforms	Marked Occasionally
Pelvic Infections in Females	< 1		X	Other Coliforms Anaerobes Coliforms Enterococci Staphylococci	Marked Marked Moderate Moderate Occasionally
Purulent Meningitis	< 1	X X X		Meningococci Pneumococci H. influenzae	Marked Marked Marked
		X	X	Staphylococci Streptococci (gp. A)	Occasionally Occasionally
			X	Other Virus	Occasionally None
Serous Meningitis	< 1	X		Tuberculosis Fungi	Occasionally Occasionally
Postoperative Infections (including peritonitis)	< 1		X	Staphylococci "Coliforms" Enterococci	Marked Moderate Moderate
Medical Shock	< 1		X	Anaerobes Coliforms	Occasionally Marked

* = Relative Frequency based on Viral Upper Respiratory Illness as 1000.

** = Marked variation with age most common 0-2 years.

have had little difficulty in choosing a single drug regimen for over 95% of such patients.

On the other hand, postoperative infections are often difficult to diagnose and have a wide etiologic spectrum. The use of "standard" regimens has not been very successful for this reason, particularly since the pattern in a hospital may well change as the result of the use of such a regimen. Treatment again should be individualized on the clinical characteristics and its urgency and plentiful pretreatment cultures obtained. Almost a special situation often complicating the postoperative course is medical shock. Most of these patients have gram negative rod bacteremia. In some hospitals chloramphenicol has been recommended but many, at least 10%, of the patients will not respond to this drug. Kanamycin and polymyxin can be used judiciously. A single dose of each will distribute adequately and have little toxicity. If renal function is absent no further drug is needed. These drugs if used should be ordered dose by dose at 12 hour intervals.

TABLE 4
RESURGENT TRENDS IN USE

Local	Burns Decubitus Ulcers Urinary-Prophylaxis
Long-Term	Chronic Bronchitis Plastic Vessels, etc.

As indicated in Table 4 there has been some renewed interest in the use of local application to minimize invasion through a burned area of skin or in decubitus ulcers. Agents recommended have ranged from sulfonamides to gentamicin, essentially the oldest to the newest. While closed urinary drainage of any type appears to reduce infections among patients with indwelling urinary catheters there is evidence that instillation of polymyxin and neomycin through a triple lumen catheter was even more effective.

Recent studies have also indicated that prolonged use of agents such as tetracycline or ampicillin lessens morbidity among the patients with highly symptomatic

chronic bronchitis or bronchiectasis. Evidence of prolongation of life or reversal of the basic disease is still lacking perhaps in part because of the difficulties in measurement which result from the variability of the course in the untreated controls.

Of increased importance in recent years has been the use of various plastic prosthetic devices on the vascular system with occasional infection of some of these. Staphylococci, including a wide variety of coagulase negative strains have been most common invaders but a wide variety of common gram negative rods also have been seen. Treatment of these patients is often difficult. When prolonged suppression has been obtained as evidenced by continuously negative cultures a replacement of the infected prosthesis might be attempted particularly if previous relapses have occurred. Since the treatment of these patients is often an intermittent process over months to years all organisms isolated from the blood from the beginning should be saved in case later events raise questions of relapse, development of resistance, and the advisability of surgery. At times prolonged suppressive therapy may be preferable to reoperation but data upon which estimates of the risk of either procedure can be made are lacking hence the problem remains.

In seeking the optimum the profession must find ways of minimizing methods of use which detract from the expected. Table 5 lists some commonly observed errors. In certain situations such as streptococcal pharyngitis, tuberculosis and endocarditis optimal duration of treatment has been empirically defined. One commonly made mis-

TABLE 5
DIFFICULTIES FROM IMPROPER USE

A. Failure to Achieve Optimal Results
1. Insufficient Treatment
2. Improper or Incomplete Follow-up
3. Inability to make Appropriate Changes in Therapy
B. Over use, including excess dose + Duration
1. Increase number of reactions
2. Contribute to development of resistant populations of organisms

take is therapy of too brief duration. Less common is underdosage. In general most treatment is in the overdose category but there are some infections for which very high doses of the less toxic drugs such as penicillin have been recommended. In these patients undertreatment is often seen. A more difficult choice is the need for treatment before diagnosis is confirmed. As indicated above, medical shock and tuberculous meningitis are two very important examples of this. Another form of undertreatment is seen in empirical use of streptomycin and chloramphenicol in many presumably prophylactic uses such as in post surgical patients. Here the use of unreasonably low doses is often observed and probably reflects the lack of need for the drug in the first place.

Since antibiotics, although remarkably reliable, are not uniformly successful, follow-up until standard criteria for complete arrest or cure are obtained is most important.

Errors in diagnosis are often corrected during the follow-up observational period.

Changes in treatment are most difficult to make in a scientific manner. They are best made on the basis of unanticipated culture results or failure to respond after an adequate trial. The latter is never less than 48 hours and probably rarely less than 72 hours. When a patient is doing well even unexpected culture results should be carefully evaluated and perhaps repeated before "a winner is deserted."

The two biggest remaining problems are the increased evidence of reactions and the propagation of population of resistant organisms. Both of these are made worse by over-use. Any excess drug, whether in dose, duration, unwarranted combination or unneeded therapy adds an increment to each of these problems. Thus these constitute the area in which the individual physician can make a real contribution to optimal results.

(continued from 309)

THE VIEW BOX--DIAGNOSIS AND DISCUSSION

Diagnosis: Congenital absence of pectoralis muscle

This patient had pneumonia. This is not what excites the radiological interest. The patient has radiolucency of $\frac{3}{4}$ of the right lower lung due to the absence of the sternocostal portion of the muscle.

In this instance the remaining clavicular segment undergoes hypertrophy and accounts for the opaque density in the apex. Inspection reveals the density to extend

into the axilla which indicates its muscular nature.

The relative emphysema of the right lower lung is due to the loss of the normal filtering and scattering effect of the muscle mass and not to any change in the underlying lung. On the left side there is absence of the pectoralis minor. Only slight disability is associated with this condition.

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COMPRESSION THERAPY IN ULCERS OF NECROBIOSIS LIPOIDICA DIABETICORUM

Sydney A. Diamond, M.D.

A CASE OF MULTIPLE ULCERATIONS of the legs (necrobiosis lipoidica diabeticorum) was successfully treated by means of compression therapy. In view of the fact that I found only one article that mentions compression therapy in the treatment of such ulcers,¹ it was felt worthwhile to report this case.

H. D., a 15 year old white girl, has been a known diabetic for 10 years. She requires 55-60 units of N.P.H. insulin daily. Her leg ulcers first appeared in January, 1963. She had two previous admissions to the University of Illinois Research and Educational Hospitals for her leg ulcers, in addition to which she has had several admissions to other hospitals for acidosis.

Physical examination revealed a 15 year old, well developed, slightly obese white girl with multiple shallow ulcers of both legs anteriorly and posteriorly. Otherwise the physical examination was negative.

When first seen in the Dermatology Clinic, on January 20, 1964, there were ulcers on both legs anteriorly and on the left leg posteriorly. On the dorsum of the right foot there was an ulcer with the long axis running across the foot. On the right leg posteriorly there was an area of necrobiosis lipoidica diabeticorum which later broke down and ulcerated. The ulcers were irregularly oval in shape and up to 10 cm x 7 cm in size, about 2-3 mm in depth, with sharply inclined edges. The bases were covered with a dirty grayish, greenish white exudate.

From January to April, 1964, she was treated with compresses of Burow's solution, Erythromycin ointment, and subsequently Tetracycline 250 mg t.i.d. Cultures and sensitivity tests showed that the organisms found were responsive to these agents; however, the ulcers remained unchanged.

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It was then decided to use compression therapy on the right leg, using the left leg as a control. A four-inch Elastoplast* was used, which at first was changed weekly. Later, because of the discharge and odor, the bandages were changed twice weekly. The patient developed an extensive superficial dermatitis and pyoderma of the right leg. Because the ulcers showed healing, it was nevertheless decided to continue the compression therapy. Within 3 weeks the ulcers had healed considerably; and the patient was now instructed in the use of a four-inch rubber elastic bandage, the Tensor** bandage. Bacitracin was used to clear up the pyoderma. Five weeks after starting the compression, the dermatitis was completely healed; and the ulcers of the right leg showed considerable healing, while those on the left showed none. At this time the Tensor bandage was started on the left leg.

The patient was advised to continue therapy as outlined and told to use vaseline to prevent the gauze from sticking to the ulcers.

COMMENT

Trauma is often given as an antecedent to the development of lesions of necrobiosis lipoidica diabeticorum or to their ulceration; however, in many cases no history of injury can be elicited.

The treatment of necrobiosis lipoidica diabeticorum and/or its ulcerations is far from satisfactory. Originally, it was felt that control of the diabetic state would control the lesions; but it was soon found that it did not appear to influence the course of the dermatosis.⁴ Surgical excision and grafting have been used;^{5, 6} but it is felt that the latter is a dangerous procedure.⁷ Intralesional hydrocortisone acetate has given some favorable results.

*Duke Laboratories.

**Bauer and Black.

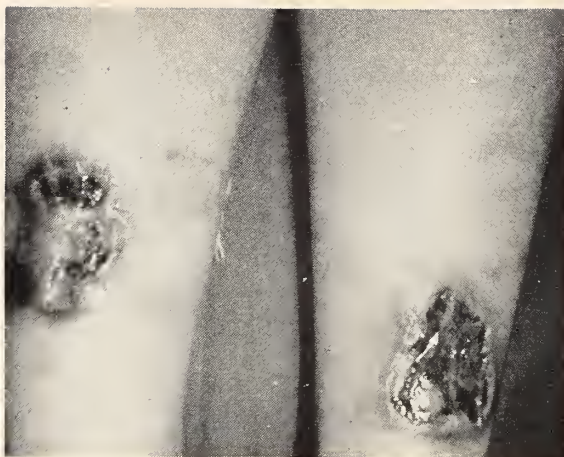


Figure 1. Untreated necrobiotic ulcer.

Compression bandaging has produced favorable results; but it must be done properly in order to accomplish this. Beginning just below the bend of the knee, the entire leg is wrapped with four-inch Elastoplast in a spiral manner down to the phalangeal-metatarsal joints, being sure to include the heel. The bandage is applied as tightly as possible. The free end of the Elastoplast is secured with adhesive tape. Squares of Elastoplast are placed directly over the ulcer to prevent cutting from the edges of the Elastoplast which is wound around the leg. Four-inch gauze squares are placed dependently to absorb the discharge which occurs; and the bend of the ankle is padded with at least two or three gauze squares. The Elastoplast is changed at weekly intervals, unless there is too much discharge. If so, the bandage is changed twice weekly. If a severe dermatitis or pyoderma ensues, then the patient is instructed as to the use of a four-inch rubber elastic bandage.

The patient must be impressed with the fact that the Tensor elastic bandage is to be worn as tightly as possible and that (1) it must be applied before getting out of bed; (2) it must be worn throughout the waking hours; (3) it must be tightened during the day if necessary; and (4) it must be removed only on retiring.

No ointment or creams are used with the Elastoplast. Vaseline is used in conjunction with the rubber elastic bandage only to prevent the gauze from sticking to the ulcers.



Figure 2. Results of compression therapy.

Antibiotics are not used systemically or topically on the ulcer itself, as infection does not play a major role in influencing healing. Humphris states: "Infection per se is of no importance in the delay of healing of ulcers, and routine cultures are a waste of time and money."⁸ Dale states: "Antiseptics and dyes placed directly on the ulcer are to be completely avoided. While they destroy harmful bacteria, they also necrose tissue cells and retard healing. To date, there is no form of local medication which will increase the speed of healing, although there are bland ointments or solutions which apparently do not retard healing."⁹

SUMMARY

A case of ulcers occurring in necrobiosis lipoidica diabetorum is presented, which was healed by the use of compression bandages of four-inch Elastoplast and four-inch rubber elastic bandages. It is emphasized that neither local nor systemic antibiotics is needed, nor are they of value.

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MANAGEMENT OF CAUSES OF VAGINAL DISCHARGE (ESPECIALLY TRICHOMONIASIS AND MYCOSIS)

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BY REQUEST, DISCUSSION will be on vaginal discharge with emphasis on vaginal trichomoniasis and vaginal mycosis. Vaginal discharge is one of the frequent obstetric and gynecologic complaints.

A number of conditions have been associated with excessive moisture or discharge at the introitus. These can be divided into two categories: the non-infectious and the infectious. Only a limited number will be mentioned (Table 1). Vaginal discharge causes symptoms of discomfort or irritation at the introitus and not within the vagina. Thus, vulvar and vaginal conditions must be distinguished. The freedom from vaginal symptoms is explained by the absence of certain nerve endings in the vagina. Accordingly, the moisture at the introitus is related to pruritus, and/or irritation. In this light, examination must be inclusive of the vulva, vagina and cervix, to determine the source or cause of the condition.

NON-INFECTIOUS STATES

The non-infectious vaginal states associated with discharge include among others, the following. Burns or chemical reaction result from failure to provide proper dilution or from hypersensitization to a product. Irradiational reactions, although effective for carcinoma, may be followed by discharge. Foreign bodies (pessaries, tampons, sponges and other items) favor pressure necrosis and other reactions.

The preadolescent girl may have persistent vulvo-vaginal discharge because of a foreign body in the vagina. Objects like safety pins, peanuts, caps of medicine droppers illustrate the possibilities. Because

of radiational insult to the ovary, x-ray pictures are not advised. Moreover, the nature of some material may not produce a shadow by Roentgen rays. The use of a small electrically lighted urethroscope is the recommended method. The individuals should not be forcibly restrained for the examination. Unless the patient will cooperate willingly, examination under gas anesthesia is urged to avoid the psychologic trauma. After the foreign body is removed, 0.1 to 0.2 stilbestrol daily for one week and then three times for the second week should be adequate.

Neoplasms, benign and malignant, especially those protruding from the uterine cavity through the cervix into the vagina, are often associated with excessive moisture. Advanced malignancies may cause vaginal fistulas, such as recto-vaginal or vesico-vaginal. Probably the most often overlooked is excessive cervical secretion.

The increased secretion may be from erosion, cervicitis or cervical gland stimulation from estrogens, passive vascular congestion or sexual activity. The increased outpouring of the mucoid material is discovered only by careful inspection of the cervix.

INFECTIOUS STATES

The infectious states include a number of conditions. Less common today than four decades ago are the venereal diseases. Except for gonococcal infection of the urethra and cervix, the symptoms of the venereal diseases usually are unrelated to discharge. The diagnosis of gonorrhea is made by smear or cultural examinations. The treatment is well established for the adult. In the preadolescent girl, the vagina may be considerably involved in gonorrheal infection. Penicillin is the drug of choice. The use of diethylstilbestrol in 0.1 to 0.2 mgm. amounts daily for 7 days and then on alternate days for two weeks more should be

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TABLE 1

**SOME LOWER GENITAL TRACT DISEASES
LIKELY ASSOCIATED WITH
VAGINAL DISCHARGE**

<i>INFECTIOUS</i>	<i>NON-INFECTIOUS</i>
Trichomoniasis	Excessive cervical secretion
Mycosis	Foreign body
Postmenopausal vaginitis	Neoplasms, benign cysts, endometriosis, polyps, etc.
Childhood vaginitis—non-specific	Neoplasms, malignant primary and secondary
Venereal diseases syphilis gonorrhea granuloma inguinale	Chemical and burn reaction
Tuberculosis	Irradiation
Others	Others

adequate in conjunction with the antibiotic.

Postmenopausal vaginitis may be due to a number of organisms. It is usually considered as a non-specific infection. It is probably somewhat like the non-specific infections in the preadolescent. The postmenopausal patient may have the infection following trauma, even coitus, because of its thin mucosa. Postmenopausal vaginitis responds almost magically to 0.5 mgm. diethylstilbestrol daily by mouth. After 2 to 4 weeks, the dosage may be reduced to 3 to 4 times weekly. This therapy can be continued for many years, even in the absence of menopausal symptoms. Estrogens will keep the vaginal mucosa healthy. Furthermore, recent studies by Davis, Jones and Jarolim⁴ have shown that women on estrogens after menopause have a significant and statistically lower incidence of coronary heart disease.

Mycosis and trichomoniasis are the two entities of concern today.

INCIDENCE OF VAGINAL TRICHOMONIASIS AND MYCOSIS

The actual incidence of vaginal trichomoniasis is not known. It is generally agreed that factors of economics, morality and others are associated with variables. Thus, speculation prevails on the total number of women involved yearly in this country with vaginal trichomoniasis. Estimates

have ranged from 500,000 to 3 million women annually. This condition occurs mostly in reproductive age, and may occur in virgins. This disease is found both in the gravid and nongravid patients. It is known that some individuals are carriers of the vaginal trichomonad, totally free from symptoms, and clinically normal.

The incidence of vaginal mycosis varies considerably. Johnson and Mayne¹² found the *Candida albicans* in about 37% of their gravid patients.

Woodruff and Hesseltine¹⁸ found by cultural means from symptom-free, normal pregnant patients, percentages varying from about 15% to 40% in three different groups. The 15% were in a higher economic and sociologic group. A 33% incidence came from a Caucasian group in a dispensary and a 40% incidence occurred in an ethnic group at this same station.

Gillespie, Inmon and Slater⁷ had a *Candida* species incidence of about 46%. Benham and Hopkins² demonstrated that the *Candida albicans* may be a normal inhabitant of the skin, mouth and intestines. It may be found in water and on certain foods.

DIAGNOSIS OF VAGINAL TRICHOMONIASIS AND MYCOSIS AND POSTMENOPAUSAL VAGINITIS

Thus the recovery of trichomonads or *Candida albicans* from the vagina does not establish that either is disease producing in the given patient. With the incidence being distinctly higher than the clinical entity, diagnosis of the clinical entity must be made by a dependable and reliable process. The use of culture media for fungi has paved the way for gross misinterpretation of diagnosis. A vaginal mycosis, if it exists, will be associated with a caseous-like material or thrush-like patches on the vaginal walls. One invariable symptom is itch and not just irritation. One can easily, by hanging drop, find mycelia under low-powered microscopic examination. If one chooses, a gram stain of the smear will do equally well. Cytologic "smear" can be employed, but mycelia, not just buds or *conidia*, must be found to be positive for diagnosis of

vaginal mycosis. The mycelia are distinct and specific. Unless mycelia are present, the patient's symptoms are not due to the *Candida albicans*. The erroneous reliance upon positive culture has led to false accusations on therapeutic failure. It is not the fault of therapy, it is the fault of diagnosis. Therefore, cultures are not only unreliable for diagnosis, but actually misleading and medically wrong. From a diagnostic viewpoint, all cultural material should be completely discarded.

The near ubiquitous nature of the *Candida albicans* favors its presence in the vagina frequently. The predisposition in pregnancy for vaginal mycosis is explained by the increase in the glycogen-like material in the vaginal mucosa. This material breaks up into common sugars upon which these organisms thrive.

Vaginal trichomoniasis diagnosis is made by finding the flagellate in a moist or hanging drop. Kean, Day and Wolinska¹⁴ used the hanging drop, culture method and cytologic method for evaluation. The culture method may be only slightly superior for recovering of the organisms, but it is complicated, time consuming and more expensive. Clark and Solomons³ found that the culture method was workable, but in the ordinary office practice, probably less desirable. The quickest and easiest method is by the use of the hanging drop. The upper vagina and vaginal portion of the cervix is stippled or "strawberry-like." The surface may be roughened. The discharge has a fetid or foul odor. It is yellowish and typically bubbly.

Little doubt exists about the question of pathogenicity of the vaginal trichomonads. The experiments of Hesseltine, Wolters and Campbell¹⁰ revealed that this infection could be produced by inoculation. Those with normal vaginal flora were the most resistant.

Pruritus is not typical—but irritation is present as a rule.

Postmenopausal vaginitis occurs as implied after the menopause. The diagnosis is made by exclusion of foreign body and trichomoniasis. The thin layer of mucosa

is easily broken. It responds slowly to healing, except under the stimulation of estrogens.

Excessive cervical secretion is established by direct inspection.

THERAPY—POSTMENOPAUSAL VAGINITIS AND EXCESSIVE CERVICAL SECRETION

Postmenopausal vaginitis will be avoided by those patients on proper estrogenic therapy. When the condition develops, it will respond physiologically within one to two weeks to estrogenic administration. The mucosa will appear like that during child-bearing years. The estrogens may be given subcutaneously, intravaginally, or orally. The authors recommend 0.5 mgm. enteric coated diethylstilbestrol tablets orally daily (on retiring or with a particular meal) for two to three weeks. The frequency may be reduced to four times weekly (Monday, Wednesday, Friday and Saturday) or three times weekly (Monday, Wednesday and Friday). Few patients may have breast discomfort with the daily dosage. An occasional patient may get along adequately on the above dosage twice weekly (Monday and Thursday).

Because of the betterment in cholesterol metabolism and reduction in coronary heart disease by prolonged administration, it is good practice to continue postmenopausal patients on estrogen 0.5 mgm. two to four times weekly (as above) for an indefinite number of years. The exception would be patients who had had mammary or genital cancer. There is no known risk for the development of malignancy because of estrogenic intake.

Excessive cervical secretion can be treated by silver nitrate stick application to the involved area and the canal. It should be done in the first half of the menstrual cycle and not oftener than once every two months. Douches mechanically remove discharge, but do not attack the cause.

Even so, one heaping teaspoonful of powdered alum or two tablespoons of sodium chloride (table salt) in one quart of

water may be used daily for one month for symptomatic relief after the chemical cauterization.

If satisfactory response fails after two applications of silver nitrate (cauterization of the cervix would be contraindicated generally in the presence of an abnormal cytologic smear or a suspicious lesion), one may use electric desiccation cautiously in the first half of the cycle. The above described douche may be used for comfort.

THERAPY FOR VAGINAL MYCOSIS

The effective agents for vaginal mycosis have been limited in number. A product known as Propion Gel was developed by Alter, Jones and Carter.¹ It contains both the calcium and sodium salts of and also propionic acid. Suran and Greenblatt¹⁷ obtained satisfactory results. An antibiotic product, Mycostatin, has been recommended. It is expensive in comparison. In 1949, Hesseltine and Beckette⁹ reported the specificity of ricinolic acid and oxyquinoline. In 1955,⁸ a subsequent report confirmed that ricinolic acid was the specific factor. The product's name is Aci-Jel. The cure rate continues to be about 95% for obstetric and gynecological vaginal mycosis with only a 5% failure rate. Because fungi are so common and pregnancy favors this fungous infection, this condition can be common. The Aci-Jel is deposited in the vagina nightly on retiring. Treatment may be continued to term or begun in late pregnancy without risk to the individual. Unlike gentian violet, Aci-Jel is without irritation. It is safe, stainless, colorless, odorless, dependable and easy to handle. The treatment is by daily insertion of Aci-Jel for two to four weeks. The frequency is then gradually reduced and finally discontinued. Vaginal mycosis may be encountered any time from early pregnancy up until near term. It is more common from the end of the first trimester to the middle of the last trimester.

TREATMENT OF VAGINAL TRICHOMONIASIS

Many therapies have been developed, but fortunately, a new and specific product

known as metronidazole (Flagyl) has come onto the market.

This drug has been shown by Kane, McFadzean, Squires, King and Nicol¹³ to follow a good absorption and excretion pattern. Good serum concentration was found by Gray, Kane and Squires⁶ and Gray.⁵ The drug was excreted in the milk and was transported to the fetus. Its value was confirmed by investigators in France, England, Germany, other European countries, Canada, and the United States. The current literature in the U.S. makes reference to most of the principal workers. Lyon, Sinykin and Barr¹⁶ had a favorable report. Hesseltine and Lefebvre,^{11, 15} including references to some of the principal investigators, had a 10% failure in their initial group of 289 patients, but on repeated treatments, reduced the rate to 2.2%. This series totals 487, with 11.1% failure with the first course of therapy. On repeating the course up to five times, the failure rate has been reduced to 3.9%. This percent equals nineteen cases, ten of whom became carriers, and nine were lost.

In the course of study of metronidazole, 44 in 390 cases (11.3%) patients had a temporary drop in the white count, and a tendency toward a reversal of the polymorphonuclear leucocytes and lymphocytes. This state reverted to normal with two weeks of cessation of therapy.

The dosage for metronidazole is a 250 mgm. tablets orally with each of three meals daily for ten days. This makes a total dosage of 7,500 milligrams in 10 days. Only the patient is treated. Although no fetal injury has been demonstrated, it is recommended that therapy be avoided in pregnancy altogether or at least until mid-pregnancy.

Present data indicate that the fetus is safe with early therapy, but more cases are needed to prove the safety of therapy. Since vaginal trichomoniasis is not a fatal disease, this therapy should not be prescribed in the first three months or first trimester of gestation. Husbands should not be treated unless an infection can be found in them. Lefebvre and Hesseltine¹⁵ report that only two husbands had infections in

seven of the failed cases as evaluated by urologists. The fact that the final failure rate was only 3.9% implies that husbands are seldom involved.

Two cases not identified in this report had "failures." Both of them were cured with the regular oral dosage of Flagyl for ten days and one 500 mgm. vaginal insert for five days. This aspect needs further investigation because of the increased amount of drug. Even though not one serious complication has been attributed to this drug, surely sooner or later, someone will have an unusual reaction. Before a husband is treated, he should be examined to make sure that there is reason for it.

SUMMARY

Both vaginal trichomoniasis and vaginal mycosis can be diagnosed readily in the office by a hanging drop. Mycosis can be diagnosed also by stained smear or by cytologic smear. Unless the mycelia or trichomonads are present, the disease entity does not exist. Treatment by cultural guidance or treatment without correct diagnosis can only contribute to failures in the correction of the patient's problem.

To prevent such error, it is urged that cultural tubes for fungi be discarded.

Vaginal mycosis or *Candida albicans* infection can be treated most successfully by Aci-Jel by vaginal deposition. It is economical, odorless, colorless, stainless, and nonirritating.

Vaginal trichomoniasis can be treated most successfully with Flagyl. It is taken orally, one 250 mgm. tablet three times daily for ten days only. Until fetal safety is assured, therapy in pregnancy should be avoided. Only infected husbands should be treated.

Postmenopausal vaginitis responds excellently to 0.5 mgm. Diethylstilbestrol (enteric coated) for two to four weeks. The dosage may then be reduced to a proper amount to fit the individual case.

Excessive cervical secretion is too often inadvertently overlooked. Its treatment is

by chemical cauterization or possibly gentle electric desiccation.

Therefore the doctor's office is an essential and functional diagnostic and therapeutic unit in control of vaginal discharge. This is notably true of the vaginal mycosis and trichomoniasis.

Appreciation is expressed for the cooperation of the entire staff in this study. G. D. Searle and Company are thanked for their generous contribution of metronidazole (Flagyl) for the vaginal trichomoniasis therapy.

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THE EPIDEMIOLOGY AND TREATMENT OF STROKES IN LAKE COUNTY, ILLINOIS

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AN INCREASING INTEREST IN "STROKES" has been observed in the United States in the last ten to twenty years. This has happened as the diseases killing and crippling the younger population are less prevalent and the diseases of old age, of which stroke is one, increase.

In 1960 vascular lesions of the central nervous system, of which stroke is the major component, were the third leading cause of death in the United States. They were also the third leading cause of death in Illinois and in Lake County.¹ According to the United States Public Health Service there are at least two million hemiplegics in the United States. On the basis of this figure, it is stated that strokes are the most disabling single condition affecting the adult population.²

The Princeton Conference of Cerebrovascular Disease (1954-1957) pointed out (1) how desperately information of all types is needed concerning the group of diseases so often lumped under the heading "stroke," and (2) how urgent is the need for the application of proven methods in

the diagnosis and management of stroke cases.

The Heart Association of Lake County, in accord with this statement, has recently formed a Stroke Committee, for which an internist and the county health officer serve as co-chairmen. In order to provide this committee with information on the epidemiology of strokes in Lake County, a study was made of the problem as it existed in the 1963 calendar year. This paper presents the results of this study.

Method

Various studies on the epidemiology of strokes have been done elsewhere. Some of these were reviewed and ideas were gained from them. Within the limited time available, it was decided to review the charts of patients hospitalized in a single year (1963) in the six general hospitals in Lake County. The hospitals participating in the project were: Condell Memorial Hospital, Libertyville; Zion-Benton Hospital, Zion; Victory Memorial Hospital and St. Therese Hospital, Waukegan; Lake Forest Hospital, Lake Forest; Highland Park Hospital Foundation, in Highland Park.

To simplify the review of charts, an information retrieval sheet was prepared. No effort was made to determine the number of strokes which occurred but were not hospitalized. The number of persons in Lake County dying from strokes was obtained

Senior medical student at Northwestern University Medical School, Chicago, Illinois. This study was conducted during a three-month clinical clerkship spent with the Lake County Health Department, Waukegan, Illinois, under the supervision of Arthur G. Baker, M.D., M.P.H., Medical Director.

TABLE 1

		Age of Patients					
		<40	41-50	51-60	61-70	71-80	<80
Thrombosis	Male	0	2	5	12	14	11
	Female	0	3	7	11	21	14
	Total Deaths	0	0	2	6	10	7
	Hosp. Stay	..	12.2	26.1	20.5	30	17.4
Hemorrhage	Male	0	2	8	13	14	5
	Female	1	0	10	12	12	5
	Total Deaths	0	0	9	13	17	9
	Hosp. Stay	2	20	25.6	21.9	37.2	23
Embolism	Male	0	0	2	1	0	0
	Female	0	2	1	1	1	1
	Total Deaths	0	1	1	0	1	1
	Hosp. Stay	..	5	17	44	..	..
CVA	Male	0	1	6	7	9	7
	Female	1	1	3	8	13	4
	Total Deaths	0	2	0	7	9	3
	Hosp. Stay	17	..	19.3	12.1	19.6	18
SAH	Male	2	2	0	1	1	0
	Female	2	2	1	0	0	0
	Total Deaths	0	3	1	0	1	0
	Hospital Stay	9	104	..	47	..	..

"Stay" refers to the number of days in the hospital for the group who lived in each age group.

from the Bureau of Statistics of the Illinois Department of Public Health and compared with the number of deaths found in the hospital.

Information from hospital charts was sought pertaining to age, sex, and race. The number of associated diseases and of previous strokes was recorded. The initial physical findings and the course in the hospital were included. Particular attention was given to the use of physical therapy, angiography, and lumbar punctures. Information on the disposition and condition of the patient on leaving the hospital was also sought.

As a part of the study, physical therapists were visited and asked to estimate the number of stroke patients they saw on an outpatient basis. Information on the number of stroke patients in nursing homes was also obtained.

Results

A total of 266 strokes were hospitalized in 1963, and charts of these patients in the listed six hospitals were reviewed. It

was found that there were rather wide discrepancies between hospital size and the number of strokes treated.

Of the 266 patients, 139 were female and 127 were male. (See Table 1) The age range was from 25 to 96 years, with an average being 69.2 years. If subarachnoid hemorrhages were included, the overall age is 68.2 years. The average age for men (excluding SAH) was 69.3 years. The average age for women was 69.1 years. There were nine Negroes in the study—2 males and 7 females. The population of Lake County is 320,000 (estimated—1963)—approximately 95.7% white and 4.3% non-white.

Of the 266 patients, 62 (23.3%) had had a previous stroke, and 16 (25.8%) of these died. Nineteen patients (7.2%) had pre-existent diabetes and five (26.3%) of these died. Eighty (30%) had a history of hypertension and 35 (43.7%) of these expired. Sixty-seven (25.2%) had a history of heart disease, of which 35 (52.3%) died. Of the above patients, several had more than one disease and therefore are counted

TABLE 2

Hospital	A	B	C	D	E	F
No. of Patients	119	51	38	26	26	6
Male	56	23	20	14	12	4
Female	63	28	18	12	14	2
< 65 yrs.	47	13	15	10	8	1
65-75 yrs.	42	20	10	8	11	3
76 & older	30	18	13	6	7	2
No. lumbar punctures excluding SAH	13	11	2	3	3	1
Angiograms	2	2	0	1	0	0
Decubiti	4	1	2	2	1	0
Seen by PT	34 (28.6%)	14 (27.5%)	11 (29.0%)	8 (30.8%)	6 (23.0%)	1 (16.7%)
Deaths	40 (33.6%)	23 (45.0%)	20 (52.6%)	10 (38.4%)	9 (34.6%)	2 (33.0%)
Autopsies	8	7	1	1	2	0

more than once. Of those having a recorded blood pressure at the time of admission, in 96 (36.1%) it was higher than 140/90. In addition, 38 patients (14.3%) had only a high systolic pressure (higher than 140).

While in the hospital, 74 patients received physical therapy by a physical therapist, and three others received physical therapy from a registered nurse. Fifteen received anticoagulants. Of the 266 patients, 104 (40%) died in the hospital (see Table 1), 31 died within 24 hours; 38 between 24 hours and 7 days; 30 between 7 days and 31 days; and 5 after more than 31 days of hospitalization. Of the 104 deaths, 25 (24%) were due to cerebral thrombosis, cerebral hemorrhage accounted for 48 (46.2%), cerebral embolism for 4 (3.8%), subarachnoid hemorrhage for 5 (4.8%), cerebrovascular accidents, not otherwise defined, for 22 (21.2%).

Of all the charts reviewed, 18 strokes occurred in patients admitted for reasons other than stroke and who apparently experienced a stroke while in the hospital. Five of these patients were male; 13 were female.

There were 100 cases (38%) diagnosed as thrombosis, 44 male and 56 female. Cerebral hemorrhage accounted for 85 cases (31.9%) with 43 being male and 42 female. There were 9 cerebral emboli

(3.4%) — 3 male, and 6 female. Ten (3.8%) subarachnoid hemorrhages occurred — 5 male and 5 female. Fifty-nine (22.2%) were diagnosed as cerebrovascular accident only, 30 of which were male and 29 female. There were three (1.1%) miscellaneous (spasm and cerebrovascular insufficiency).

The patients were discharged with one of four dispositions. Seventeen (6%) were transferred to another hospital; 104 (40%) died during the hospitalization being reviewed; 120 (45%) went home; and 25 (9%) went to nursing homes.

The six different hospitals were rather similar in the type (age and sex) of patients treated. Some tended to do more lumbar punctures and angiograms than others. (See Table 2) Also the number of autopsies performed varied widely. Generally, the treatment seemed rather similar in all six hospitals.

Seasonal variation is a very minimal factor in the incidence of strokes in Lake County, the study revealed. (See Tables 3a & 3b)

The following information was obtained regarding outpatient physical therapy performed in 1963 for stroke patients: (all stroke patients regardless of the time of occurrence of their stroke are included.)

Easter Seal Rehabilitation Center	58 patients
Community Nursing Service	15 patients
Hospital Physical Therapy (estimated by PT's)	544-644 patients

In a previous study of diagnoses of patients in nursing homes, it was found that there were 707 patients in nursing homes in Lake County as of May 1, 1964. One hundred seven (15.1%) of these were diagnosed as cerebrovascular accidents—34 males and 73 females.³

Discussion

The study found that 266 stroke patients were hospitalized in 1963 in Lake County hospitals. There were 104 hospital deaths among this number. Figures from the Illinois Department of Public Health showed that in the same year there were 222 deaths in Lake County attributed to strokes on death certificates. (See Table 4)

From these figures, it can be seen that almost half of the stroke deaths occurred in the hospital. The number of strokes occurring in the community in which death did not result and which were never hospitalized could not be ascertained from this study. Also the number of strokes which occurred but were not recognized as such could not be determined.

The age of patients having cerebrovascular accidents was 69.2 years, compared with 64.4 years in a Florida study of 100 persons.⁴ The men were slightly older than the women in this study, but not significantly so. As might be expected, the patients diagnosed with subarachnoid hemorrhages were of a younger age group.

The overall incidence of cerebrovascular

accidents in Lake County per 100,000 population was 83.1. That rate for Negroes was 64.3 and for whites was 84.0. These figures should probably be doubled to cover the strokes which were not hospitalized.

There were slightly more women than men in this study (139 to 127). The difference here seems too small to draw any conclusion.

The history of associated disease and its prognostic value in relation to death was interesting. Similar facts were sought in Jarrell's study⁵ and Robinson's study⁶. The Lake County study showed a higher percentage of patients with no previous known disease, 138 (52%) compared to 20% in Jarrell's study. Much of this is due to the previous study being based on histories taken with the study outline in mind, whereas the charts reviewed in the Lake County study were random histories. We found hypertension as the commonest associated disease (80 patients) and heart disease as the second commonest (67 patients). Diabetes was a poor third. Polycythemia was found in two patients, gout in one, and epilepsy in one. This was the same general picture as found by Jarrell. We recorded the number of deaths occurring in each group and found that 52.3% of the patients with heart disease died, and that 43.7% with hypertension recorded died. The overall death rate in our patients was 40%. Of those having a history of a previous stroke, only 25.8% died and of those with diabetes, 26.3% died. From these figures we might conclude that possibly pre-existent heart disease and/or hypertension led to a poorer prognosis for the patients. On the basis of these figures, only a tentative conclusion can be reached.

The number of patients having a recorded

TABLE 3a—Males

	Winter	Spring	Summer	Fall
Male	34	31	31	31
Thrombosis	10	13	12	9
Hemorrhage	15	7	8	12
Embolism	1	0	1	1
CVA	8	8	8	6
Other	0	3	2	3

TABLE 3b—Females

	Winter	Spring	Summer	Fall
Female	36	40	34	29
Thrombosis	15	18	11	12
Hemorrhage	11	15	9	7
Embolism	0	1	2	2
CVA	9	5	10	6
Other	1	1	2	2

TABLE 4

Cause	Death Certificates	From Study	% Found in Study
Subarachnoid Hemorrhage	14	5	35.7%
Cerebral Hemorrhage	106	48	45.3%
Cerebral Embolism, Thrombosis	84	29	29.0%
Spasm of Cerebral Arteries	0	0	----
Vascular Lesions-NEC	18	0	0%
CVA's unspecified	0	22	----
TOTAL	222	104	46.8%

blood pressure higher than normal was greater than the number of patients with a history of increased blood pressure. This may have been due to the stress of hospitalization experience, or perhaps to the many patients from whom an accurate history was unobtainable. Many of the patients on whom increased blood pressures were recorded went back to normal blood pressures during their hospitalization.

Those patients that lived had an average hospital stay of 23.3 days. This varied with age and etiology as can be seen in Table 1. The persons who died expired after an average of 9.0 days in the hospital. The females averaged 10.8 days and the males 7.0 days.

There were very few decubitus ulcers and these seemed equally distributed among the men and women. No hospital had any preponderance of decubiti. (See Table 2)

The number of lumbar punctures done was 33 for 255 patients, the subarachnoid hemorrhages being excluded. In some hospitals a higher percentage of spinal taps was performed than in others. (See Table 2) This seemed to be one of the valid areas of difference in medical practice among the six hospitals.

The number of angiograms done, excluding those done for subarachnoid hemorrhages, were too few to draw any conclusions. (See Table 2)

The percentage of patients dying differed rather significantly among the hospitals. (See Table 2) When the age of the patients served by the hospital is noted, this tends to account for the discrepancies as a higher proportion of older age patients was as-

sociated with a higher percentage of deaths. When death occurred, it was usually soon after the occurrence of the stroke. This is similar to what has been observed by other authors.⁷

The number of patients with each diagnosis showed a different distribution than usually suggested to occur in the literature.^{8, 9} The low number of thromboses, 100 (37.6%) compared to the anticipated amount, 66% may well be due to the fact that thromboses are better tolerated than hemorrhages, fewer deaths occur, and the patient is not as severely incapacitated. The patient may decide, either with or without the physician's advice, to stay at home rather than to be hospitalized. Also the observed figure would be somewhat higher if those patients diagnosed only as "cerebrovascular accidents" were distributed to other diagnoses.

There were more cerebral hemorrhages (31.9%) than expected (21%). Here the redistribution of the diagnosis "cerebrovascular accident" would widen the discrepancy. Many patients with cerebral hemorrhages die before hospitalization occurs. However the usual severity of a cerebral hemorrhage would probably encourage hospitalization. The fact that the highest percentage of deaths in this study, compared to actual death certificates, was in the category of cerebral hemorrhage, tends to support this thesis. (See Table 4)

The incidence of cerebral embolism and subarachnoid hemorrhage was somewhat lower than expected. This could be accounted for partially by a redistribution of the cerebrovascular accident diagnosis.

The percentage of patients receiving physical therapy varied among hospitals. When the age of patients and the number of deaths are considered, the figures tend to become fairly comparable. From study of the hospital charts a subjective opinion was formed that there were a number of patients who could have benefited from physical therapy but did not receive it.

The number of patients anticoagulated was 15. No conclusions were reached about these patients. The disposition of the patients was within the expected range.

A previous study of nursing home patients indicates the size of the stroke problem—15% of all patients in these institutions. A program is already under way by the Lake County Health Department and the Lake County Easter Seal Rehabilitation Center to work with nursing homes in improving their care of stroke patients.

As can be seen from the figures, Community Nursing Service and the Easter Seal Rehabilitation Center are serving many patients. Some come to the Center and some are followed at home. Most of the case load is being handled by the physical therapists in connection with the hospitals and in their private practices.

In general, stroke patients are being well cared for in Lake County. Two areas needing emphasis are: definitive diagnosis and rehabilitation after discharge from the hospital.

Summary

This study was undertaken to study the epidemiology of strokes and their treatment in Lake County, Illinois. Hospitalized strokes were sought out and their charts reviewed. Charts of 266 stroke patients were studied—139 female and 127 male. Of these, 100 were due to cerebral thrombosis, 85 to cerebral hemorrhages, 9 to cerebral emboli, 10 to subarachnoid hemorrhages, and 59 were diagnosed as cerebrovascular accidents only. 104 deaths occurred. The average age was 69.2 years. In general, the treatment of strokes was felt to be at a high level. Two areas where improvement was needed were in definitive diagnosis and rehabilitation after strokes.

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EDITORIALS

DINING TOO WELL

THE KINGS DRINK the cream and get fat; the serfs drink skim milk and get strong. This oldie was apropos of the age of gluttony when rulers ate like pigs and threw the crumbs to the servants and dogs. Philip Lindsay's portrayal of Henry VIII at the table is perhaps one of the better descriptions of a man enjoying his meal with gusto.

"Dinner with King Henry VIII at Enfield Palace in July 1541: The king ate enormously, stuffing the meat into his little mouth with his knife. As he munched, the meat and vegetables popping from cheek to cheek, his eyes shone with happiness. He jabbed his knife, greasy as it was, into the saltcellar, blew his nose on his napkin, spat into the washing bowl—he was the king. The meat was soaked with sauces of parsley, garlic, quince, pear, wine; there were great pastries, glittering with sugar, or hiding haunches of venison cooked to rags and powdered with ginger; there was veal boiled with sage and smeared with cinnamon, cloves and saffron, stiffened with eggs, all buried under pastry dotted with dates. Then came dessert of perfumed fruits and candied flowers, violets, roses, primroses, and hawthorn. Men fell on one knee to offer more things for that little mouth to bolt. Anything was thrown into it. He grabbed from dish to dish, and when food

was on its way and he was forced to pause, he would seize a handful of raisins or almonds and fling them into his mouth . . ."

The orientals did almost as well and the same can be said of the Romans. It is unfortunate that the menus of the celebrated feast of Belshazzar are lost because they were the most famous of all gorges. "Four and twenty black birds baked in a pie" always sounded like a fairy tale until I read about the supper given by Petronius in his Feast of Trimalchio. Among almost everything on the table was an enormous wild sow, "out of which flew a flock of live thrushes." The pig was surrounded by a litter of little pigs made of some kind of cake-paste.

We doubt if the heart association would approve of these meals. Their latest recommendation is to (1) eat less animal fat, (2) increase intake of vegetable oils and other polyunsaturated fats, (3) eat less foods rich in cholesterol, (4) if overweight, eat less, and (5) apply these dietary recommendations early in life and make sound food habits a "family affair."

We are aware of the relationship of fats to atherosclerosis but we might sum up the recommendations in three words. "Avoid gluttonous eating."

T. R. Van Dellen, M.D.

THE HOUSE CALL

The practice of modern medicine has bypassed the house call because it is time consuming and hospital facilities are more suitable for the care of the seriously ill. Treating everyone in the office and hospital has the advantage of improving patient

care and shortening the disability period.

On the other hand there are many advantages to the treatment of patients at home because the physician obtains first hand information on how, where, and with whom the individual lives. The home en-

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vironment plays an important etiological role in many psychosomatic disorders. The patient may not complain but the cause for emotional upsets is obvious the moment the physician enters the door. This is true especially when the spouse is lazy, messy, overbearing, or incompetent. Poverty or mismanagement may account for weight loss and insecurity. Now and then the patient turns out to be a recluse or the sole support of too many inlaws or a vegetating father or mother.

Drs. Richard D. and Joseph R. Wiseman¹ believe in making a house call on most of their allergy patients. They obtain a better insight into the home environment so as to make practical suggestions on eliminating possible allergens. An asthmatic was sensitive to horse dander yet was sleeping with a saddle under the bed. In another instance they found 50 canaries in the room adjoining the bedroom of a feather sensitive severely asthmatic patient. A house visit is a must when the individual fails to respond to accepted drugs and suggestions. The family may not be aware

of the need for 24 hour precautions. A 13-year-old asthmatic girl slept in a second floor room on foam pillows and foam mattress. Her mother thought that all the proper types of dust precautions were installed but usually put several stuffed pillows and stuffed animals on the bed during the day. These contained well known allergens and would have escaped detection except for the house visit.

The New York allergists find that a few minutes in the home uncovers more information than an hour of history taking in the office.

Many elderly people also prefer to remain at home when ill and in addition the home care of those in moderate financial circumstances saves considerable money. Many youngsters have gone through college on the money saved by treating their dying father at home.

T. R. Van Dellen, M.D.

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HYPONATREMIA IN THE NEWBORN CAUSED BY HYPONATREMIA IN THE MOTHER

The improper administration of intravenous fluids to a mother at term resulting in hyponatremia in the mother, may also cause hyponatremia in the newborn. This important finding was reported by Doctor Leslie B. Alstatt.¹ He reported on four cases of hyponatremia of the newborn. These infants exhibited lethargy, hypotonia, poor color and seizure activity. The infants had serum sodium concentrations from 114 to 122 mEq. per liter. The mothers had serum sodium concentrations ranging from 117 to 119 mEq. per liter. All four infants recovered after being given saline containing solutions.

The author states that these studies confirm the studies of Battaglia and his group who found that the changes in fetal sodium concentration closely parallel those in the mother's serum.²

The author advises that serum sodium levels be obtained on the cord blood of infants born to mothers who have been given large quantities of sodium free solutions, especially when the mothers have been on low salt diets. He also recommends that infants having serum sodium concentrations of less than 130 mEq. per liter be given intravenous solutions of sodium chloride to elevate the serum sodium to a low normal level. This should be done whether these infants are asymptomatic or show the symptoms of hyponatremia.

Harvey Kravitz, M.D.

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DISASTER MEDICAL CARE

The Illinois Medical Assistants are studying the problem of peacetime or wartime disaster medical care. Typical of the way in which the IMAA members are preparing themselves are the programs the Du Page County Chapter held at its May meeting, and the De Kalb County Chapter held in March.

The Du Page County members heard Dr. Max Klinghoffer, chairman of the Medical Disaster Care Committee of the Illinois State Medical Society, discuss the package disaster emergency hospital. Dr. Klinghoffer stated that medical disaster care is divided into six areas:

1. A central civil defense co-ordinating body
2. Fixed hospital disaster plan
3. Package emergency disaster hospitals
4. Shelter program
5. School disaster program
6. Medical Self-Help Training

The U. S. Office of Civil Defense acts as the central co-ordinating body. Each hospital has a disaster plan to handle large scale emergencies. Memorial Hospital in Elmhurst has set up such a plan, which has been used as the model which many state and national plans have followed.

The shelter program is intended to save 50 to 60 million lives. This aspect of disaster care is in a very inadequate state of preparedness. The Medical Self Help program is intended to assist in maintaining health and alleviating suffering during a period of national emergency when professional care and normal services may not be available. It covers preparation for health care in emergency, care of the injured and ill, birth in a shelter, and facing the fallout problem. It also covers provision for sanitary care, food, water and emergency supplies.

Dr. Klinghoffer said there are two types of emergency hospitals. One type is set up in school gymnasiums with materials for patient care provided by local doctors and pharmacists. This is a field type of hospital, designed for peacetime disasters or future wartime needs. The need for these units is tremendous in time of war, as it is estimated that one million of the 1½ million hospital beds would be destroyed. There are now 2,000 package hospitals stored throughout the U.S. in nonmetropolitan areas, with 62 located in Illinois. Each unit is capable of handling a maximum of 800 beds. These are all located at least 15 miles outside the probable wartime target areas.

There are two types of package hospital units—those that are pre-positioned and are not opened until needed, and those that are used regularly for training purposes and used as needed.

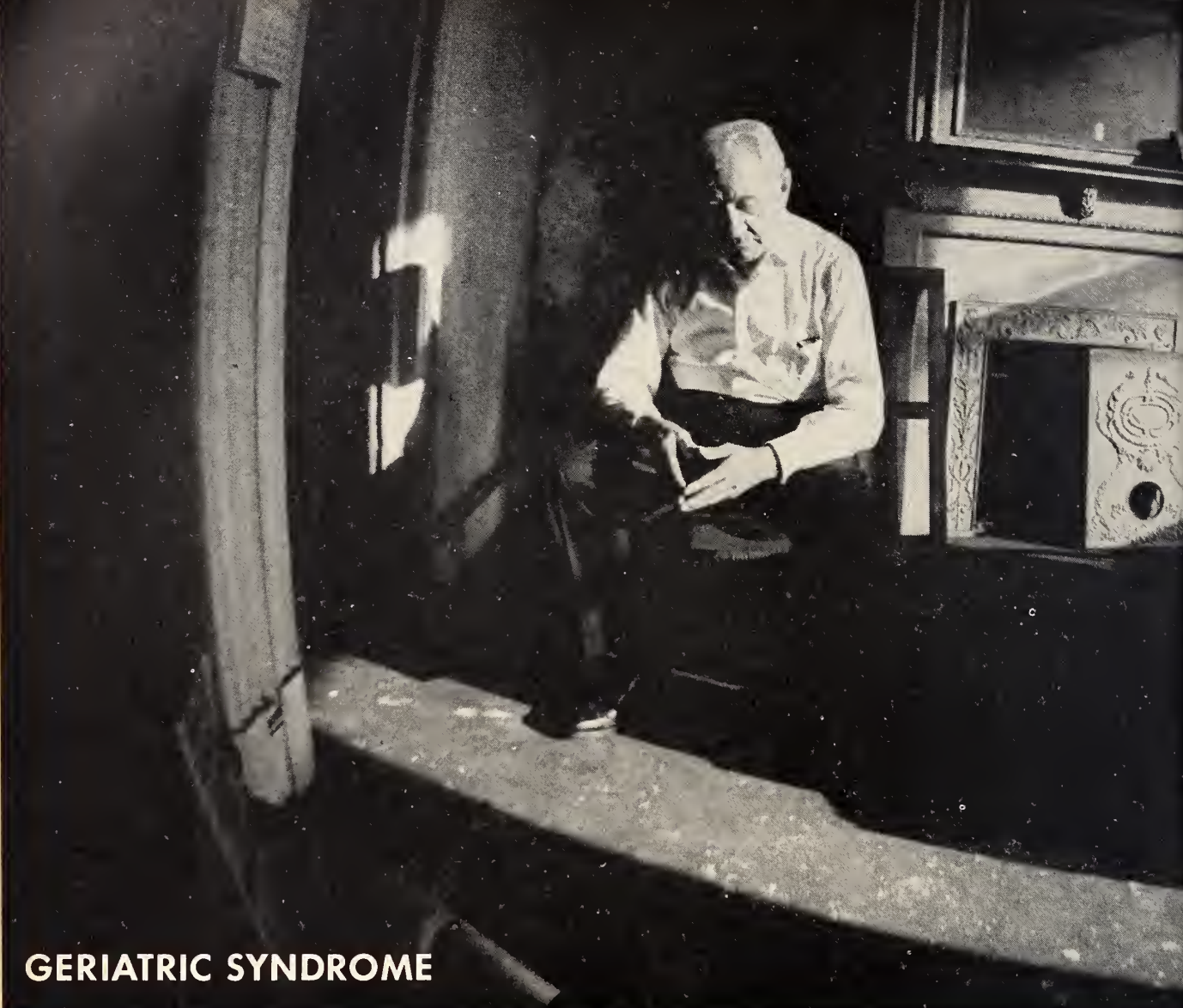
Each package hospital contains a triage area; decontamination area; surgery facilities, including five folding operating tables; x-ray and laboratory facilities; pharmacies; a morgue; wards of various kinds such as general, burns, orthopedic, obstetrical, etc.; and a dismissal area. These hospitals may contain our medical stockpile in the event of war.

With the exception of three heavy pieces—the water supply tank, the generator and x-ray equipment—the supplies could be handled by women. The packages are color-coded for contents.

According to Dr. Klinghoffer, there is a serious shortage of personnel trained to set up and operate these hospitals.

As a first step to prepare themselves in the event of an emergency, the Du Page County Medical Assistants voted to take the Medical Self Help Training course.

... continued on page 363



GERIATRIC SYNDROME

when a change in environment overwhelms him with anxiety

Failing health, financial difficulties, or the death of a spouse are among the reasons why elderly people may be obliged to leave their familiar surroundings. Moving in with children or entering a home for the aged may satisfy practical requirements but can be psychologically traumatic since emotional resilience tends to diminish with age.

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The De Kalb chapter heard Mr. Montgomery of the De Kalb County Civil Defense Committee speak on Disaster Defense. He emphasized that this spring's devastating tornadoes had underscored the fact that civil defense is not defense of the citizen in time of war only, but that disasters of storms, tornadoes and floods are also civil defense problems. The first step in preparedness is in knowing what to do in case of disaster.

In the event of a tornado, an underground excavation or storm cellar is the safest place to be. If unable to find this protection, Mr. Montgomery outlines the following as the next best course or procedure:

1. If in open country, move at right angles to the tornado's path. Tornadoes usually travel between 25 and 40 mph.
2. If there is no time to escape, lie flat in the nearest ditch or ravine.
3. If in the city, seek inside shelter, away from windows. If at home, the corner of the basement toward the tornado. If there is no basement, protection may be had by getting under heavy furniture that is pushed to an inside wall.
4. Doors and windows on the sides of the house away from the tornado should be opened to help reduce damage of the home due to air pressure.

Recognizing the tornado when you see it is another step in being prepared. Tornadoes can occur anywhere, but most frequently in the midwest, southern and central states, March through December. They occur up to 12 times in some years, during hot sticky days with southerly winds and threatening sky. The clouds often have a greenish-black color. Tornadoes strike most often between the hours of 1 and 10 p.m. They generally travel from the southwest to the northeast with wind speeds up to 500 mph within the tornado. The tornado cloud is funnel shaped, spinning rapidly, extending toward the earth from the base of a thundercloud. The path may be only a few yards or hundreds of yards wide.



The Doctor's Library

PREVENTIVE MEDICINE, 500 pages, edited by Herman E. Hilleboe, M.D., and Granville W. Larimore, M.D., W. B. Saunders Company, Philadelphia, Pennsylvania, 1965.

Private practitioners and public health team members use the term preventive medicine to fit their own purposes. While this book does not clarify these overlapping connotations, it updates a fine previous text (1959) and relates the contributions to preventive medicine by the public health physician (including the psychiatrist) who is the leader of the public health team as well as teammates such as engineers, entomologists, laboratorians, researchers, nutritionists, dentists, social scientists, health educators, public health nurses, hospital administrators, bio-statisticians and administrators.

The internist, who next to the pediatrician is perhaps most inclined to the use of preventive medicine in his practice, will benefit from studying the contents of this book. The internist, being available in even greater numbers than other specialties, contributes importantly to the level of public health (considering public health as a sum of total individual health). It is basic that he understand the organization of public health services in his community.

The control of environmental factors as in Section A, "Prevention of Occurrence," updates the new complexities that beset our civilization. Personal survival is increasingly dependent upon awareness of changing factors and the physician as the leader of the health team and most confidential advisor of the private patient bears great responsibility. A new angle of illumination is given the presentation of such subjects as provision of adequate nutrition and elimination of pre-disease conditions, including preventive dentistry, all of which will enhance the physician's continued learning process. Knowing all of the facts about ionizing radiation as updated in this text will enable the internist to be something of a specialist in an area where more concentration is needed to protect the public health. This quote (p. 44) will illustrate, "Because of the increasing use of radiation in industry and medicine in recent years as well as the exposure of whole populations to significant amounts of radioactivity dispersed throughout the world as a result of nuclear weapons testing, radiation safety has become one of the nation's most important public health problems."

The practicing internist could also good naturedly stimulate his local health officer by knowing

all of the material in this excellent text. One possible defect of this book is that it does not contain enough material on the new "community health services" concept which demonstrates that the physician health officer and his team are interested not only in a community as a whole (protecting them in ways they cannot protect themselves) but also in the individual patient's health. This concept is exemplified in the provision of home health services by the public health nurse.

Franklin D. Yoder, M.D.

THE SPECIALTIES IN GENERAL PRACTICE, Russell L. Cecil & Howard F. Conn. W. B. Saunders Company, Philadelphia, Penn., 1964, \$17.50.

This book serves as a useful, ready handbook for general practitioners. The editors are well known and the 18 contributors are distinguished in their specialties. Several chapters were combined in this third edition for the sake of comprehensive coverage. The chapter on orthopedic trauma, for example, is a combination of the previous chapters on orthopedic surgery and fractures and dislocations. Chapters on Clinical Laboratory, Neurology, and Industrial Medicine were added to broaden the value of this book. We object to combining syphilology and dermatology in the same chapter because syphilis is not primarily a skin disorder. On the other hand the chapter on psychiatry is well organized.

T. R. Van Dellen, M.D.

CORRECTABLE RENAL HYPERTENSION by Chester C. Winter.

An important medical maxim is "You hardly ever find what you don't look for." Chester Winter with his development of the radioactive renogram and with his obvious interest in renal artery lesions has made a great contribution to the field of hypertension. As a result of his techniques and interest many groups are diagnosing many more instances of "renal artery hypertension" than had ever been considered to be a reasonable estimate.

Dr. Winter's small book (138 pages if the preliminary pages, index, and bibliography are ignored) presents data on all the important aspects of the diagnosis, and treatment of "renal artery hypertension." But, with rare exception only the bare data, or even just conclusions of others are presented very briefly. The critical reader finds it difficult to detect what Dr. Winter thinks on many important problems. For instance, on page 37 a short paragraph is devoted to "Ptosis and Clinical Hypertension." A few references are given, followed by two sentences:

- (1) "Cure of hypertension has been effected by nephropexy."
- (2) "Further consideration of ptosis will be given."

The evidence for statement (1) is sadly lacking. And subsequent consideration of "ptosis" is limited to its inclusion in Table 1 as a "lesion capable of producing hypertension."

As far as this reviewer could tell, Dr. Winter first expresses his own opinion on page 60, in a brief and not very useful paragraph beginning on line 7. And again, selection of remarks on subjects such as renal biopsies (middle paragraph of page 118) often are useless ("Local or general anesthesia is a matter of choice by the surgeon and the patient.")!

Despite these critical remarks the illustrative material presented in this small book is excellent, and should stimulate physicians to utilize the necessary curiosity, intelligence, knowledge and techniques to find more instances of one of the common "correctable" causes of hypertension. Any physician who sees hypertensive patients can learn much from this book, provided he will recognize its limitations.

David P. Earle, M.D.

POLYPOID LESIONS OF THE GASTROINTESTINAL TRACT. Claude E. Welch, M.D., 148 pages, W. B. Saunders Co., Philadelphia, 1965.

Since 1958 when Ackerman challenged the concept that intestinal adenomas degenerate into cancer, there has been some uncertainty regarding treatment of polypoid lesions of the colon and rectum. True, most clinicians hold to the time-honored tenet. However, an uneasy feeling has persisted that Ackerman might be right, that no association exists between adenomata and cancer.

The present volume by Welch goes far toward clarifying the relationship of polyps and cancer. He has reported a vast experience, not only his own, but that of the Massachusetts General Hospital. The excellent tabular data testify to the large number of cases studied and to the careful observations made as part of their clinical investigation.

It is quite natural that discussion of polypoid lesions of the colon and rectum occupy a large proportion of space in this volume. Problems of treatment of multiple polyps and familial polyposis are detailed. Practical consideration of diagnosis and treatment of these lesions in various locations are explained.

The illustrations in this book are impressive. Similarly, clear line drawings and well reproduced X-ray films combine to emphasize the concise statements of the text. Welch's economy of words should be emulated in other texts. He is able to transmit a quantity of information in short space without sacrificing style. This is a book for surgeons, pathologists, and all students of diseases of the alimentary tract.

John J. Bergen, M.D.

PAIN IN THE CHEST. William H. Wehrmacher, M.D., 403 pages, 77 illustrations. \$14.00. Charles C Thomas, Springfield, Illinois, 1964.

Chest pain is one of the most frequent symptoms encountered by the practicing physician. The ability to determine the origin of chest pain often requires considerable thought and proper interpretation of the laboratory aids. Dr. Wehrmacher has written a veritable encyclopedia on this subject and presents it in a clear, refreshing, and readable fashion. There is no doubt that in the years devoted to the preparation of this treatise he has reviewed the problem thoroughly.

I can, without reservation, heartily recommend the addition of this book to the library of any physician interested in this subject. He will find it a most useful tool in his practice and will obtain considerable help from this source.

Maurice Gore, M.D.

SURGERY OF THE BILIARY PASSAGES AND THE PANCREAS. Walter Hess. Translated by Heinrich Lamm, D. Van Nostrand Company, Inc., Princeton, New Jersey, 1965.

This book is a comprehensive presentation of the surgery of the biliary tract and pancreas. The clinical reports in the book are based on 1654 cases emphasizing the wide experience of the author. The volume is well organized. The first chapter is devoted to the surgical anatomy and physiology of the biliary tract. The anatomical descriptions are particularly good and the illustrations are clear and well selected.

The second section in the book deals with the diseases of the biliary tract and pancreas. Diagnostic techniques are well outlined, and the interpretation of the findings discussed in detail.

The author differs from the majority of surgeons in this country by his recommendation of laparoscopy (peritoneoscopy) in the differential diagnosis of icterus and for the purpose of liver biopsy. At the same time, he is reluctant to use percutaneous cholangiography, which he considers too hazardous.

Considerable attention is devoted to description of operative techniques and to radiologic diagnostic procedure which are useful at the time of operation. Operative procedures are illustrated quite adequately and are described in the text in detail. The author includes the indications for operation and discusses the postoperative course and complications.

A bibliography follows each section. The references are of interest because both American and European journals are listed.

This book should be of interest to any surgeon interested in biliary tract diseases and should be an excellent reference for resident surgeons. The translator seems to have accomplished an accurate and careful rendition of the original and has used terms familiar to surgeons in this country.

John M. Beal, M.D.

"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., *Canad. Psychiat. Assn. J.* 4(S): 1-12, 1959

**anxiety
depression
depression**



Chronic Disease Symposium

Mt. Sinai Hospital Medical Center has announced a symposium, sponsored by the United States Health Service, to be held October 20-December 15, 1965.

The five full-day seminars will be as follows:

October 20: "Chronic Obstructive Lung Disease," Albert Hass, M.D.; November 3: "Cardiac Disabilities," speaker to be announced; November 17: "CVA Stroke," Clark Millikan, M.D.; December 1: "Arthritis and Orthopedic Disabilities," Edward Compere, M.D.; and December 15: "Degenerative Neurological Diseases," speaker to be announced.

For further information and registration contact: Aaron M. Rosenthal, M.D., Chairman, Department of Physical Medicine and Rehabilitation, Mt. Sinai Hospital Medical Center, California Ave. at 15th St., Chicago 60601.

Essay Contest

A prize of \$2,500 will be awarded by the University of Colorado School of Medicine to the physician-author of the best paper on "Thrombophlebitis and Basic Vascular Problems" in the fourth nation-wide Cochems Competition.

Funds for the prize were provided in the will of the late Mrs. Jane Nugent Cochems of Denver. The Colorado National Bank of Denver, Trustees of the Cochems Estate, asked the CU School of Medicine to conduct the competition. It is open to all persons holding the M.D. degree who are citizens of the United States.

Dr. John J. Conger, CU vice president for medical affairs and dean of the school, announces manuscripts submitted in competition for the fourth Cochems Prize must be received on or before November 15, 1965.

Judges of the competition again this year will be Dr. Michael E. DeBakey, professor and head of the Department of Surgery at Baylor University College of Medicine; and Dr. Sol Sherry, professor of medicine, Washington University School of Medicine,

St. Louis. Decision of the judges will be announced early in 1966.

Inquiries regarding the 1965 competition may be addressed to Dean Conger at the University of Colorado Medical Center, 4200 E. Ninth Ave., Denver, Colo. 80220.

The Joseph A. Capps Prize

The Institute of Medicine of Chicago is offering an annual prize of \$759 for the most meritorious research in medicine or the specialties of medicine carried on in 1965. The investigation may also be in the fundamental sciences, provided the work has a definite bearing on some medical problem.

The contest is open to graduates of Chicago medical schools who have completed their internship or one year of laboratory work within a period of five years prior to January 1, 1965, excluding terms of service in the Armed Forces. Manuscripts should be submitted to the Secretary of the Institute, 332 S. Michigan Ave., Chicago 60604, not later than December 31, 1965.

Chicago Medical School Offers Postgraduate Psychiatric Courses

Basic and advanced courses in psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatrists are again being offered by the Department of Psychiatry and Neurology of the Chicago Medical School.

The aim of the postgraduate program is to increase the skills of the physician in the diagnosis and treatment of his general patient case load and in the management of psychiatric problems which require limited goal therapy.

Courses will be offered beginning October 13, 1965. There will be a limited enrollment and advance registration is required. More information can be obtained from Bernard Block, M.D., Director, Continuing Education, Department of Psychiatry and Neurology, the Chicago Medical School at Mount Sinai Hospital, 2755 W. 15th St., Chicago 60608.

Miss Ruffino Joins Journal Staff



Miss Claudette Ruffino has joined the staff of the Illinois Medical Journal as Assistant-to-the-Editor, effective Monday, August 16. Miss Ruffino is a native Chicagoan and a graduate of Mundelein College. She was Production Editor for three years on *Chicago Medicine*, official publication of the Chicago Medical Society, before coming to ISMS.

We welcome Miss Ruffino to ISMS and wish her every success in her new position.

Appointments

Dr. Harold L. Method, assistant professor of surgery at Northwestern University Medical School, was installed as president of the medical staff of Passavant Memorial Hospital at the staff's annual dinner meeting Tuesday night (June 1) at the Drake Hotel.

Dr. Method succeeds Dr. Conover Talbot, associate in medicine at Northwestern.

Dr. Method received his bachelor of science degree from Northwestern University in 1940 and his medical degree in 1943. Following service with the U.S. Navy Medical Corps, he served surgical residencies at Passavant and at Cook County hospitals.

Dr. Method is a past president of the Northwestern Medical Alumni Association and received its Alumni Service Award in 1959. He has received the Chicago Surgical Society Award for his research.

In January Dr. Method was presented the 1964 Sports Illustrated Magazine Silver Anniversary All-American Award by Governor Otto Kerner in Springfield. As captain of Northwestern's football team in 1939, Dr. Method was one of 25 of the nation's well-known professional men who were outstanding all-American football players on collegiate gridirons 25 years ago.

Dr. William R. Roach, assistant professor in obstetrics and gynecology at Northwestern, was named president-elect of the Passavant medical staff, installation to take place next June. Dr. Gerry A. Smyth, associate in medicine, was re-elected secretary of the staff.

Dr. Talbot presided at the dinner which was attended by Passavant's Board of Directors, its Woman's Board and physicians in training at the hospital.

Albert I. Rubenstone, M.D., has been appointed Pathologist and Associate Director of Laboratories at Mount Sinai Hospital. Dr. Rubenstone has also been appointed Professor of Pathology at the Chicago Medical School.

Dr. Rubenstone comes to Mount Sinai from Philadelphia where he had been chief of Laboratory Services at the Veterans Administration Hospital since 1962.

Alexander Ruggie, M.D., has been named Director of Medical Education at Lutheran General Hospital, assuming his duties on a part-time basis.

Dr. Ruggie has been on the staff of the Lutheran General since the hospital opened in 1960. He is in his second year as president of the medical staff and was chief of medicine at the hospital during its first three years of operation.

Gordon L. Snider, M.D., has been promoted to Professor of Medicine at the Chicago Medical School. Dr. Snider, who joined the faculty in 1958, is also chief of the division of thoracic medicine at Mount Sinai Hospital and director of the pulmonary function laboratory at the Municipal Tuberculosis Sanitarium.

He is past president of the Illinois Chapter of the American College of Chest Physicians and secretary of the College's national committee on pulmonary physiology.

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Meeting Memos



September 20 to October 2.—The Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in Laryngology and Bronchoesophagology. This course is limited to fifteen physicians, and will be under the direction of Paul H. Holinger, M.D. It will be held at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago. Instruction will be provided by means of animal demonstrations, and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lecturers. Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Postoffice Box 6998, Chicago.

September 20-Oct. 29—A six-week Medical Teacher Training Program will be conducted at the University of Illinois College of Medicine, Chicago.

Through seminars based on selected readings, and working sessions built on specific problems, participants will study the process of learning, methods of teaching, and evaluation of programs.

The course will be conducted by the U. of I.'s Center for the Study of Medical Education and Division of University Extension. A registration fee of \$35 per person will be charged, and participants also will pay for their own food and lodging. Enrollment is limited to a small group of medical faculty members from the U. of I. and other Institutions.

Dr. Thomas C. King is chairman of the program. Faculty will include William R. Crawford, Dr. Lawrence A. Fisher, Seymour Friedberg, Christine McGuire, Dr. George E. Miller, and Dr. John Williamson. Other members of the College of Medicine faculty will serve as resource persons on specific topics.

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This is one in a series of advertisements describing some of the services offered at the hospital.

October 10—The annual scientific meeting of the American College of Nutrition will be held at the Americana Hotel in New York City at 10 a.m. The topic will be "Nutrition — Alcohol — Office Practice." For further information, please contact Robert A. Peterman, M.D., F.A.C.N., Secretary, 3 Craig Court, Totowa Borough, New Jersey, 07512.

Oct. 12-14—The 1965 Congress on Occupational Health, sponsored annually by the American Medical Association's Council on Occupational Health, will be held concurrently with the annual convention of the Indiana State Medical Association.

The two and one-half day meeting will be held at the Murat Temple in Indianapolis, Tuesday through Thursday.

A special feature of the meeting will be a 25th anniversary Congress on Occupational Health reception and dinner on Thursday evening in honor of former members of the Council on Occupational Health. James H. Sterner, M.D., corporate medical director, Eastman Kodak Company, Rochester, N.Y., will be master of ceremonies.

For additional information write: Department of Occupational Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, or to the Indiana State Medical Association, 3935 North Meridian Street, Indianapolis, Indiana 46208.

October 13-14—A two-day postgraduate course on "THE CLINICAL APPLICATION OF CURRENT CONCEPTS IN RENAL PATHOPHYSIOLOGY" will be offered at The University of Wisconsin in Madison.

The course, coordinated by the University of Wisconsin Extension has been designed to present an organized review and appraisal of current knowledge in several major areas of renal disease and to relate this knowledge to the evaluation and management of clinical renal problems.

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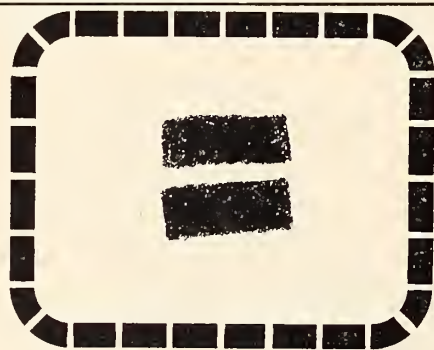
SPECIALTY REVIEW COURSE IN SURGERY,
 Part I, November 8
 SPECIALTY REVIEW COURSE IN MEDICINE,
 Part I, September 27
 SPECIALTY REVIEW COURSE IN PEDIATRICS,
 Parts I & II, September 27
 SPECIALTY REVIEW COURSE IN GYN-OB,
 Two Weeks, October 25
 PRINCIPLES OF OPERATIVE SURGERY, Two Weeks, October 4
 SURGERY OF STOMACH & DUODENUM,
 One Week, September 20
 SURGERY OF THE HAND, One Week, September 13
 SURGERY OF FACE & MOUTH, One Week, October 11
 ADVANCES IN SURGERY, One Week, October 4
 THORACIC SURGERY, One Week, September 27
 BLOOD VESSEL SURGERY, One Week, October 25
 UROLOGY, Two Weeks, October 25
 VAGINAL SURGERY, One Week, October 25
 ADVANCES IN OB-GYN, One Week, October 4
 FRACTURES & TRAUMATIC SURGERY,
 Two Weeks, September 20
 ADVANCES IN MEDICINE, One Week, October 4
 BASIC ELECTROCARDIOGRAPHY, One Week, September 27
 CLINICAL USES OF RADIOISOTOPES, Two Weeks, October 4
 GENERAL PRACTICE REVIEW, One Week, October 18
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Meeting Memos . . . continued

consin Medical School staff and from institutions throughout the United States will comprise the institute faculty.

Additional information may be obtained from Paul Knipping, 403 Extension Building, University of Wisconsin, Madison, Wisconsin 53706.

Oct. 30-31—The 16th National Conference on Disaster Medical Care will be held at The Drake in Chicago, it was announced by Albert H. Schwichtenberg, M.D., chairman of the American Medical Association's Council on National Security.

Four symposiums—Care of the Traumatized Patient, Disaster Communications, Disaster Planning in Industry, Disaster Medical Resources—will be held during the two-day period to develop the conference theme of unified health resources planning for disaster.

"The Red Cross in Disaster" will be the subject of a Saturday luncheon address by Robert F. Shea, Washington, D. C., vice president, American National Red Cross. James Z. Appel, M.D., Lancaster, Pa., AMA president will address the conference Sunday morning.

Three representatives of the federal government will conclude Saturday's discussions with a presentation of the role of "Federal Agencies in Disaster."

A special Disaster Tornado Report will be presented during a Sunday morning breakfast session. A second highlight of Sunday morning's session will be three separate workshops specifically designed for the physician, allied health worker, and community leaders.

Following a presentation of the New York method of planning for disaster, William T. Ramage, Jr., M.D., Louisville, Ky., program chairman, will deliver the conference summary.

For additional information write: Council on National Security, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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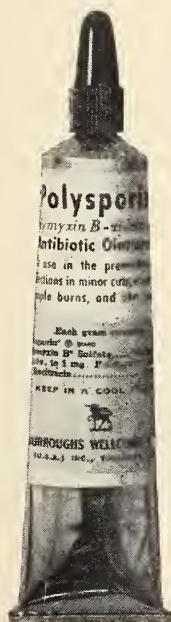
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OBITUARIES

Fred C. Blackwelder, Litchfield, died July 21, aged 89. He was a graduate of the University of Illinois College of Medicine in 1900.

Marne Cataldo*, Oak Park, died July 16, aged 46. He was a graduate of the University of Chicago School of Medicine in 1945, a staff member of Oak Park hospital and chief of staff for internal medicine at Walther Memorial hospital.

Francis X. Graff*, Freeport, died July 11, aged 62. A graduate of Chicago Medical School in 1933, he was former chief of staff at St. Francis hospital. Doctor Graff was a Diplomat of the American College of Surgeons, charter member of the Society of Abdominal Surgeons and a member of the International College of Surgeons.

John M. Grimes, Chicago, died April 13, aged 80. He was a graduate of Rush Medical College in 1925.

Frederick J. Hisgen, Chicago, died June 6, aged 81. A radiologist at St. Bernard and Evangelical hospitals, he retired in 1960.

Emil T. Hoverson*, Midlothian, died July 12, aged 61. A graduate of Northwestern University Medical School in 1931, he was former president of Hazel Crest General hospital.

Frederick H. Kampf*, Michigan, formerly of Chicago, died June 25, aged 88. In 1914 he was a graduate of the National University of Arts & Sciences Medical Department, St. Louis. He was an emeritus member of ISMS.

Mieczyslaw J. Kostrzewski*, Chicago, died August 9, aged 74. He was a graduate of Chicago College of Medicine & Surgery in 1912. He had been a staff member of Norwegian-American hospital for over 50 years.

Maurice B. Laven*, Chicago, died July 11, aged 64. He was a graduate of the University of Illinois College of Medicine in 1927. A staff member of Michael Reese & Jackson Park hospital, he was also a lieutenant colonel in the Army medical corps reserve.

Carl T. Lewerenz, Chicago, died July 12, aged 67.

A graduate of Marquette University School of Medicine, Milwaukee in 1928, he specialized in obstetrics & gynecology. He was a member of the American Society of Clinical Hypnosis and the American Society of Abdominal Surgeons.

John E. Lotspieck*, Chicago, died July 29, age 66. He was a graduate of Northwestern University Medical School in 1927.

August H. Lueders*, Hinsdale, died July 11, aged 79. He was a graduate of the University of Illinois College of Medicine in 1913.

Frank F. Maple*, Chicago, died August 7, aged 79. A graduate of Rush Medical College in 1913, he specialized in obstetrics & gynecology. He was a past president of CMS and a founder of Woodlawn hospital. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Andrew Nagy*, Chicago, died June 23, aged 64. He was a graduate of Chicago Medical School in 1935.

James Shaynin*, Chicago, died June 26, aged 87. A graduate of the University of Illinois College of Medicine in 1911, he specialized in internal medicine. He was an emeritus member of ISMS.

Carl V. Shipley*, Chicago, died July 16, aged 74. He was a graduate of Northwestern University Medical School in 1919. He retired in 1961.

Roy D. Short, Florida, formerly of Watseka, died July 4, aged 71. He was a graduate of Jenner Medical College in 1916.

Edgar W. Weir*, Atwood, died July 8, aged 63. A graduate of the University of Illinois College of Medicine in 1929, he was a member of the American Academy of General Practice.

Robert C. Woods, De Kalb, died July 22, aged 41. In 1953, he was a graduate of the University of Southern California School of Medicine, Los Angeles.

Louis C. Young*, Taylorville, died July 2, aged 60. In 1930 he was a graduate of the University of Illinois College of Medicine and he was a staff member and past president of the St. Vincent Memorial hospital.

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Illinois Medical Journal

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—president's page—

Burtis E. Montgomery, M.D.

DECISION ON RESPONSIBILITIES

The National Commission on Community Health Services, a group of 32 American citizens led by Marion B. Folsom, former Secretary of Health, Education and Welfare, has prepared a detailed series of recommendations regarding medical care and public health in the United States. Before issuing its final report to the nation, the commission has gone to considerable trouble to conduct four regional forums at which the recommendations were presented to selected individuals interested in the field of health. Physicians in private practice, as well as those in community and public health, participated.

It is reported that at the forum in Chicago, study groups discussed in depth the recommendations published in a "Report of Task Force on Organization of Community Health Services." Starting from a basis that local community health services must be better organized, the commission has gone far in its recommendations for promoting the public health. What national commission could be expected to think in terms less than at the national level? The point can be made that these recommendations are based on experiences in 21 communities, of which our own Springfield was one, but isn't it easy to overlook or minimize what is being accomplished at the state and community level and to recommend giving big government an ever-increasing job to do

locally—with the result that independent and voluntary efforts will ultimately wither away?

It strikes me that as we hurtle toward the conclusion of this report, to be presented at the National Health Council's meeting in May 1966, it would be a healthy thing if each of us made an appointment with himself to get away from the sound and the fury where he could ponder the exact nature of his responsibilities in the larger picture. Each of us should make the decision to assume the responsibilities of citizenship or to delegate them. We must not merely abdicate them.

The activities of the National Commission on Community Health Services seem to me to be a perfect example of group planning in order to fill certain voids in limited areas, also, an opportunity to give lip service to principles of individual initiative and private enterprise while organizing these fundamentals out of existence.

Participants at the regional health service forums were expected to record individual reactions to the commission's recommendations. Let us hope that those in attendance were mindful of the fact that "charity" used to have Biblical connotations and is now considered a "dirty word." We hope that word "freedom" will not go the same way.



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MENTAL HEALTH—MARCH TO EXCELLENCE

Harold M. Visotsky, M.D./chicago

Our responsibility in the march to excellence in the mental health field is to mass our efforts in one central direction. That direction is to provide services to people in crisis situations so that they receive these services at the earliest possible moment, and will not be fragmented between a multiplicity of overlapping agencies—federal, state, county, township, city, public and private.

We at the state level have made a beginning in this massive effort. The state has been divided into eight zones. In each, staff is at work with the communities planning programs tailored to their needs. Comprehensive zone mental health centers are

at various stages of completion in six of these eight zones.

The zones are intended to provide comprehensive mental health services and function as prototypes of new program concepts and treatment services. Staff at the centers will split their efforts three ways; one-third on direct services to patients, one-third on training and education within our department and outside it, and one-third on community organization, planning and consultation.

Meanwhile our department has been streamlined into eight functional divisions that encourage initiative, imagination and experimentation. At the same time the large task of making over our hospitals into other zone centers serving their immediate communities moves ahead.

To indicate the rate of change, during the past year five state hospitals received federal grants for new programs and ten more have been submitted for this year. Further, in this year's mental health week new

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*Presented before the 125th Illinois State Medical Society Annual Convention, May 17, 1965. Co-sponsored by the Chicago Neurological Society, the Illinois Psychiatric Society and the Central Neurosurgical Society.

awards program emphasizing team projects, 62 entries in five major categories were submitted.

Throughout the state at the 50 clinics that receive some \$2.5 million in grants-in-aid from the Department of Mental Health, we have seen many new and imaginative programs.

To complete the ring of planning and program development, the professional in

private practice must join the team. Although the political and social world may be a foreign realm compared to the consultation room or clinic, it is a real world where basic decisions that affect the professional are made. They should and must enter this world as students and resources. To fail to enter will result in a misunderstood point of view and an inability to alter patterns of community extrusion worked upon patients whom the professional seeks to help.

ADULT NEUROLOGY—1965

Louis D. Boshes, M.D./chicago



Cerebral Vascular Disease

During the past year there have been continuing advances made in both the medical and surgical management of cerebral vascular insufficiency as well as in the recognition and prophylaxis of both the initial and subsequent recurrent strokes. The NIH cooperative studies on anti-coagulant therapy advises this management in a small group where there is a thrombosis in evolution. However, the mortality remains the same over a long period of time whether the patient does or does not receive anti-coagulation. This is not in agreement with

Dr. J. Millikan and Dr. J. Wishnant of the Mayo Clinic who still use anti-coagulation in patients with thrombosis in evolution in the basilar-vertebral system. Patients with RIND (reversible ischemic neurological deficit) are better benefited with surgical treatment than with non-surgical treatment (medical). In patients with advanced vascular disease and with completed strokes, the converse is usually seen as reports Dr. John S. Meyer and his collaborators at Wayne University.

Infections

Sulfonamides remain the basic therapy for *meningococcal meningitis* with sulfadiazine used initially and sulfisoxazole utilized after there is a satisfactory clinical response obtained. Although the mainstay of management is still the sulfonamide, comparable results may be achieved with penicillin.

Parkinsonism

Continuing laboratory reports seem to implicate the metabolism of dopamine in the etiology of Parkinson Disease. An oral alpha-methyl-dopa has been reported as having a beneficial effect on Parkinson tremor for several hours. The evidence that muscle rigidity in Parkinson disease may be linked with a deficiency in the formation of the amine (dopamine) continues to mount,

Clinical Associate Professor of Neurology;
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particularly through the researches of Dr. Andre Barbeau of the University of Montreal.

Multiple Sclerosis

Observers continue to report epidemiological similarities between *multiple sclerosis* and *polio* suggesting that either disease may be an infectious illness on a viral basis. A correlation between the elevation of cerebral spinal fluid gammaglobulin with activation of clinical symptoms in multiple sclerosis has been noted.

Metabolic Disorders

Diabetic neuropathy continues to remain an intractable condition to manage and is felt to be a reversible metabolic defect due in great part to inadequate or ineffectual diabetic management. Denny-Brown differentiates two types of Wilson's Disease, juvenile progressive lenticular degeneration of Wilson seen in an early age from the older group the pseudosclerosis form of Westphal which begins usually in the second decade. Both conditions seem to respond to chelation.

Neuromuscular Diseases

Myasthenia Gravis. The question as to whether this is an immunologic disorder is still profound. If it is so, what role does autosensitization play in its cause? It may possibly be considered as even a vital concomitant of the disease. The concept of auto-immune pathogenesis seems still to be firm in many quarters of the country. By the same token, there is still considerable controversy as to whether radiation of the thymus or even thymectomy is more efficacious in the treatment. V. P. Perlo, Robert S. Swaub, Henry R. Viets, Kermit Osserman and G. Jenkins, in a cooperative study found that some 85% of their patients without thymomas when operated upon are still alive compared with 76% of a group of 1200 patients. The overall mortality in both groups is 24%, whereas the rate in the non-thymectomy group is 15%. There is a higher percentage of good to excellent results after thymectomy in non-tumor cases with longer survival and remissions. The

question as to why the prognosis is so poor in patients with thymoma and myasthenia gravis, even when the tumor is completely removed, still remains an enigma.

Current information regarding *muscular dystrophy* continues to reveal that increases of serum aldolase and creatine (kinase) coupled with muscle biopsies furnish the best findings for preclinical diagnosis.

Infections

Several outbreaks of *St. Louis encephalitis* have occurred in Tennessee, Kentucky, Texas especially in the city of Houston, Illinois, Indiana, Ohio, Pennsylvania and New Jersey. The Houston epidemic was the largest. The mosquito vector under suspicion is the *Culex Pipiens-Quinquefasciatus*.

Brain Scan—Radioisotope Photoscanning

This has been one of the most important developments in the growth of nuclear medicine. Especially in the last year new radiographic isotopic procedures in neurologic diagnosis have appeared. Brain scans are used regularly in the diagnosis of cerebral vascular disease and non-neoplastic and neoplastic and brain disease. Scanning is done with radioactive substances to include chlormerodrin HG 203 and chlormerodrin HG 197. At NIH there are new procedures in neurologic diagnosis developed in the recent past to include radiographic (axial-transverse encephalography) and isotopic (encephalography using radio-iodinated anti-fibrinogen RIAF ventriculography and RIAF cisternography using radio-iodinated serum - albumin methods). These are modifications and refinements to RISA pneumoencephalography. These substances are injected directly into the ventricle (radio-iodinated serum albumin-ventriculography) and when injected intrathecally are called radio-iodinated serum albumin-cisternography.

Ultra Sound in Neurologic Diagnosis

Diagnostic ultra sound continues to be used but is still confined to the determination of the presence or absence of a shift of

mid-line brain structures. This indicates the presence of an expanding lesion and is an important diagnostic procedure but still possesses limitations. The determination of the mid-line echo is of value in all patients particularly those who do not have cal pineal bodies.

Epilepsy

Several new drugs have appeared during the past year possessing value in specific types of seizures. LA-1 (Hoffmann-La Roche) is a chlordiazepoxide hydrochloride-Librium R analogue which is particularly efficacious in infants and in children with massive myclonic epilepsy and infantile spasms. Dr. Charles Markham in Los Angeles and Drs. E. M. Anderson, F. A. Gibbs, and L. D. Boshes in Chicago have used this drug with dramatic effects

Ospolot (Riker) is a new drug of value for management of the psychomotor and petit mal state. Solacen (Wallace tybamate) is a splendid drug not only with value as a tranquilizer but unlike certain other tranquilizers that have anti-epileptic properties seems to produce no fast activity in the electroencephalogram. Zarontin (Parke-Davis) continues to prove excellent in the management of children and adolescents as well as young adults with petit mal

seizures. Tegretol (Geigy) is a drug related structurally to Tofranil. S. Livingston in Baltimore and Drs. A. J. Arieff and M. Mier in Chicago have found this drug beneficial in the psychomotor state. It has also been found that Tegretol seems beneficial on patients with trigeminal neuralgia. Proloxin-Vesprin (Squibb). These two drugs are employed in the management of the emotional symptoms to include tension, anxiety, agitation, depression and dissociation in patients with psychomotor epilepsy and have proved quite efficacious. Vistaril (Pfizer) is a hydroxyzine and has been proven of value in controlling the manifestations of anxiety, tension, and psychomotor agitation of patients with psychomotor seizures.

Trauma

It is suggested by F. R. Fergerson in studying a group of boxers that boxing is sometimes the cause of progressive neurologic deficit. A question as to whether trauma plays a factor in the origin of Parkinsonism still is a moot one. Occasionally, a specific diagnosis of a post-traumatic Parkinsonism syndrome can be made, but many times the diagnosis of cerebral arteriosclerosis is made as well. The medical legal importance of this question continues.

TREATMENT OF LEUKEMIA

Five cases of treatment with extracorporeal irradiation are presented. A reduction in the level of circulating leukemic lymphocytes was achieved in all. The patient with acute lymphoblastic leukemia died without evidence of a remission. One of the 4 patients with chronic lymphocytic leukemia is clinically well, with a relatively low white-cell count, nine months after treatment. One patient has had a return of the white-cell count to high levels. In the 2 remaining patients insufficient time has elapsed for adequate evaluation.

The achievement of a relatively simple and safe method of extracorporeal irradiation in man provides a technic that should prove useful in further studies of lymphocyte physiology and pathology. The efficacy of extracorporeal irradiation in the treatment of the various types of leukemia remains to be determined.

*E. D. Thomas, M.D., et. al.,
New England J. of Med., Vol. 273, July 1, 1965, No. 1*

After attending a meeting of the Department of Mental Health Superintendents' Council I was returning to the West Side Medical Center and was amazed to see the following sign on the marquee of a Loop theater "Malamondo—Bold and Incredible Exposé of the World's Thrill Generation! Unbelievable But True! Frenzied, Frantic Youth Living It Up—Adults Only—17 years of Age and Over."

While this caption may indicate that today's teen-ager is "further out" than the past generation, it also indicates that we are more fascinated with the teen-ager than concerned and are quick to lower the age of adulthood to capitalize on the increasing purchasing power of the teen-ager. Rather than use a more traditional psychiatric approach and focus on the individual, I shall present an overview and concentrate on adolescence as a life process and discuss these facts from a sociological standpoint.

That all is not well with our teen-agers may be noted in the statistics of our courts and mental hospitals. The April 1965 issue of the *Bulletin of the Citizens Committee of the Family Court* reports an increase of 13.8 percent cases coming to the court's attention in 1964. These figures closely parallel those reported by The Children's Bureau for 1963. There were 967 thousand cases coming before the Juvenile Courts (of those reporting) of the nation in 1963—an increase of 8 percent. Except for 1961 this was consistent with an upward trend which began in 1949. Rates per thousand population indicate a proportionately higher rate in urban over rural areas.

Other statistics relating to adolescence (and children) give us concern. In 1939, 52 17-year-olds and under were admitted to Illinois State Hospitals; in 1963, 535. On June 30, 1955, 164 were in mental hospitals; by June 30, 1964, there were 720 young patients.

By and large, youths who present problems to the community may be thought of as affluent, i.e., those who are all dressed up and have no place to go and youth of "the other America" who often come from "hard-to-reach" families and have grown up in socially and culturally



THE TEEN-AGER

Raymond E. Robertson, M.D./chicago

deprived homes. The latter make up a high percentage of the adolescents in all mental hospitals and correctional institutions. These are young people who usually either have been neglected by their limited parents or come from broken homes and for whom all of us bear a significant responsibility. As we care and act on our concern the number of such youth coming to our attention will decrease. Our society needs to show much greater awareness of the needs, nature and understanding of the problems of adolescents. For instance, efforts have been made recently to raise the legal drinking age in spite of the fact that there is clear cut evidence that the onset of puberty occurs one to one and one half years earlier than it did twenty years ago.

Above are some of our youth's problems. Following is a listing of some of their accomplishments and constructive behavior as indicated by Martha Weinman Lear in her article "The Best of Teens—The Worst of Teens" appearing in the *New York Times* in November 1964:

Special Assistant to the Director, Illinois Department of Mental Health; Clinical Associate Professor of Psychiatry, University of Illinois College of Medicine.

- 1) Today's adolescents are better educated and have more money and more cars. 85 percent work during the year with earnings and allowances amounting to 2.8 billion dollars.
- 2) All have middle class aspirations even though lower socio-economic teens have difficulty in living or achieving them.
- 3) Youth have greater political awareness (than before the late President Kennedy).
- 4) Youth are growing up aware of concepts their parents never knew—TV, space exploration, peace corps, nuclear bombs, marry sooner—pay later, cold war, etc.
- 5) One half are from middle income families—two thirds are in urban-suburban communities.
- 6) Three out of ten will not graduate from high school; one half of high school graduates are college bound and one half of these may be freshmen dropouts.
- 7) Youth are more sophisticated socially, more poised with adults and freer to criticize with resultant adult defensive reaction.
- 8) Too many teens are disadvantaged and under-prepared for occupying a needed role in today's society. They are finding it increasingly difficult to play a significant constructive role in the adult world.

Having presented some impressions of today's teen-ager and his problems, I shall present two sets of facts which should be of value in work with teen-agers.

The first are the developmental tasks of adolescence. Dr. Robert Havighurst in "Developmental Tasks and Education" indicates that each individual has certain tasks to master during each period of life. A purpose of education (and family living) is to encourage and further the individual's ability to master these tasks. The developmental tasks of adolescence are:

- 1) Achieving emotional independence of parents and other adults.
- 2) Achieving new and more mature relations with age mates of both sexes

(the mores of the group became more important than parental values).

- 3) Achieving assurance of economic independence.
- 4) Selecting an occupation and preparing for it.
- 5) Achieving a masculine or feminine role.
- 6) Preparing for marriage and family life.
- 7) Accepting one's physique and using the body effectively.
- 8) Developing intellectual skills and concepts necessary for civic competence.
- 9) Desiring and achieving socially responsible behavior.
- 10) Acquiring a set of values and an ethical system as a guide to adult behavior. (The very Rev. Laurence J. McGinley, President of Fordham University, at the 1960 White House Conference said that the problems faced by the youth in the 1960s will be concerned with values and the task their parents will face will not be one of making their lives easier but of making them truly more worthwhile.)

The second set of facts are those expressed by Erich Fromm in his book "The Sane Society." Fromm indicates that each of us has basic physical and emotional needs. Only if the latter are met will one be mentally healthy. These basic emotional needs are:

- 1) The need to be related.
- 2) The need to be an individual in one's own right.
- 3) The need to be creative, productive and contribute to one's own and others' welfare.
- 4) The need to be rooted.
- 5) The need for a frame of orientation and object of devotion.

Invariably those adolescents who are troubled or who are in trouble have been unsuccessful in mastering developmental tasks of adolescence or earlier life and/or they have problems because one or more basic emotional needs have not been met. Our task is to assess the problems and utilize our knowledge and our person in helping them mature and find meaning in life.



MANAGEMENT OF MARITAL PROBLEMS

Bernard L. Greene, M.D./chicago

The speaker opened his presentation by noting that the marked variations in marital patterns and the "differences in individual needs of each spouse necessitated *flexibility* in techniques to cope best with each conflictual marriage. In the paper presented, an attempt was made to achieve systematization—a theoretical utilization of each operational approach for maximum therapeutic effect and not simply treatment by expediency. The speaker stressed that the time has passed when treatment must be placed exclusively on one spouse. The more realistic and current trend recognizes marital discord as a complex of interlocking transactions that cannot be divided into "internal" and "external" categories. A spectrum concept of operational approaches, the "six C's," was presented as a guide to the available techniques. The "six C" classification is based on a spectrum of therapeutic settings, with the dyadic approaches of classical and collaborative techniques at one end; the triadic approaches of concurrent, conjoint, and combined therapies in the middle; and conjoint family therapy at the other end.

The therapies in the management of marital problems were defined as:

1. *Counseling*—an orientation stressing socio-cultural forces and explicitly acknowledging the implications of the "here and now" situation;
2. *Classical*—an individually oriented approach;

3. *Collaborative*—the marital partners are treated by different therapists who communicate for the purpose of maintaining the marriage;
4. *Concurrent*—both spouses are treated individually but synchronously by the same therapist;
5. *Conjoint Marital*—both partners are seen together in the same session by the same therapist; and
6. *Combined*—three sub-types:
 - a. individual, concurrent and conjoint sessions in various purposeful combinations;
 - b. Collaborative-combined; and
 - c. Conjoint family therapy.

The speaker pointed out that the spectrum concept does not imply that any one psychiatrist is expected to be interested in all the varied techniques. But it is expected that the couple's needs be given prime consideration and that the therapist be prepared to discover the optimum therapy.

The speaker concluded by noting that favorable therapeutic results are less dependent on the *theoretical orientation* of the psychiatrist than on his personal characteristics, clinical maturity and empathic endowment; that psychotherapeutic methods always will retain an element of controversy; that no one form of therapy is complete in itself and equally applicable in all situations; and finally, that the significant issue is not whether a particular type of intervention was superficial or deep, but whether it was appropriate and effective for a defined condition at a defined time and within a defined life situation. Conclusions were based on a study of 250 couples.

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FOLLOW-UP OF THE DISCHARGED MENTAL PATIENT

Jackson A. Smith, M.D./chicago



Traditionally, a follow-up study was done to evaluate the effectiveness of a particular type of treatment or procedure. Such a follow-up was usually a single episode, performed to answer a question, and once this answer was obtained, the follow-up ceased.

To accomplish this end two obstacles had to be overcome: first, the discharged patient had to be located; and once found, a judgment of his improvement had to be made.

When the first phenothiazine was introduced over a decade ago and increasing numbers of patients began to be discharged from hospitals while still taking this, or some similar compound, the purpose of the follow-up changed. Since the patient was on a potent medication, which he frequently needed to continue to take, if he was going to remain outside the hospital, the follow-up became more a part of active treatment than an effort at evaluation.

Chairman of the Department of Neurology and Psychiatry, Stritch School of Medicine, Loyola University Medical School.

Therefore, in addition to locating the patient and determining the adequacy of his adjustment, his response to the compound he is taking, the dosage required and any undesirable side-effects have to be determined. The most readily available professionally qualified individual to make these determinations is the family physician.

Although there is no lack of agreement as to the importance of a follow-up clinic, this is not the sort of assignment with the most appeal to most psychiatrists. There is a tendency to prefer to treat younger, acutely ill patients rather than those more chronic who may have been hospitalized several times. Consequently, psychiatric staff time could be conserved by more fully using the family physician in the treatment of the hospitalized patient following his discharge.

One might ask why the non-psychiatric physician is not more of a help in this capacity at the present time. For one reason 75% of the 2500 physicians responding in one survey said they were seldom or never informed when their patients were discharged from a state hospital. Many of those responding added that they seldom provided "after care" because they obviously were seldom asked.

If the family physician is to function effectively as a treatment and follow-up source, he would certainly have to be informed of the patient's progress in the hospital, as well as the diagnosis and prognosis. The patient, on the other hand, would have to be advised of the necessity of regular visits following his discharge as a condition of his early return to the community. The need for these visits could not be offered as an afterthought on the day of his discharge.

FOLLOW-UP OF THE DISCHARGED MENTAL PATIENT —A DISCUSSION

Werner Tuteur, M.D./chicago



Self-criticism is always good for both the one who criticizes himself and those who listen to him. Personally, I do not share Dr. Smith's pessimism with regard to our colleagues, especially the generalists. At the frequent occasions when I address county medical societies I orient myself to the audience in a similar fashion as when I testify in court to a lay jury. I have said in the literature¹ that "once I take the stand in court I address an imaginary juror who has never listened to medical testimony before, who has never seen a psychiatrist, who knows nothing about human motivations, but who has experienced emotional conflicts in his own life." In other words, by simplifying but not oversimplifying the psychiatric issue, I usually am well understood.

The complaints by the generalist that he never hears from the psychiatrist to whom he has referred a patient is not entirely justified. I take care that every referring physician receives a report on his patient, written in nontechnical terms and in such fashion that it appeals to him. The letters are never written with an attitude that I would think the generalist is "too dumb" to understand psychiatric dynamics. In the same vein, I have no complaints with regard to referring physicians in communicating their findings to me in time and properly.

There is much need for communication between psychiatrists and other physicians, and I personally acquired this technique of communication by frequently addressing lay groups, such as Federal Probation Officers, lawyers, and other organizations exposed in their daily work to aberrant human behavior.

Dr. Smith has correctly stated that the non-psychiatrist is already familiar with

psychoactive drugs and that it should not be unsurmountable to have him function actively and beneficially in the after treatment of discharged mental hospital patients.

Elgin State Hospital opened a psychoactive drugs clinic before the first patient treated with them was ever discharged; this was as early as 1955.² Such clinics were soon copied nationwide. The groundwork has been laid, let us psychiatrists erect the beams, the walls and the roof of this building which is to shelter those who come from mental hospitals and prevent them from returning there and overcrowding them.

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CHILDHOOD SEIZURES

RESISTANT TO

CONVENTIONAL MEDICATIONS

J. Gordon Millichap, M.D./chicago

Fever, electrolyte imbalance, and subdural hematoma are some of the various causes of seizures susceptible to correction or removal. Failure to diagnose and treat specifically these and other known etiologic factors is a common explanation for poor response of seizures to empirical drug therapy. Other explanations for resistance to anticonvulsant medications include the following: (1) infantile myoclonic and akinetic seizure patterns; (2) a diffusely abnormal electroencephalogram, particularly hypsarrythmia and slow spike and wave discharges; (3) structural or degenerative cerebral lesions; (4) hypersensitivity reactions to drugs; and (5) improper selection of anticonvulsants.

The management of refractory seizures requires a careful history, and general and neurologic examinations. An electroenceph-

alogram is insufficient information alone on which to base optimum therapy but is a useful adjunct to diagnosis, prognosis, and treatment. Provided that specific therapies are not indicated, acetazolamide, the ketogenic diet, and corticotropin (ACTH) may be of value when conventional anticonvulsants have been found inadequate.

Experimental compounds with promising results in initial clinical trials include sulthiame (Trolone®), a sulfonamide which should have an action similar to acetazolamide; albutoin (Co-ord®), a thiohydantoin effective against major and possibly focal seizures; dimethadione (Eupractone®), an oxazolidine-dione effective against petit mal; and Mogadon® (RO 5-3059) and diazepam (Valium®), in the treatment of infantile myoclonic spasms resistant to ACTH.

The successful control of seizures may be expected in 75 to 80% of patients but the development of new and more effective anticonvulsant drugs is essential for the treatment of refractory seizures.

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WHO TREATS THE BURNED CHILD?

Richard C. Schultz, M.D./des plaines

A statistical study was made of all burned children hospitalized during the first five years of operation of a 326-bed, general hospital located in a suburb of Chicago (Lutheran General Hospital, Park Ridge, Illinois). The purpose of this study was originally to attempt to confirm an impression that severely burned children often come from homes with greater marital-social maladjustment than is found in the average family. This impression was gained from experience with five severely burned children from grossly maladjusted families treated in three different hospitals during the past three years. In an effort to document this, one 326-bed hospital with 36 pediatric beds was chosen because of its relatively stable suburban community location and the ease with which all pediatric burn records since the opening of the hospital could be obtained. Information gathered from the hospital record and attempted follow-up by the hospital's Social Service Department of families still living in the community failed to provide adequate information for a valid study of this problem.

In the course of this review, however, other information of a statistical nature proved to be exceedingly interesting. From

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the time of opening of this hospital on January 4, 1960 until January 4, 1965, 58 burned children were hospitalized. As would be anticipated, the general practitioner, the pediatrician, the general surgeon and the plastic surgeon were all involved in the treatment of these burned children. Insofar as the number of patients admitted was concerned, the general practice department accounted for the greatest number, 22 or 38% of the total. The pediatric service and the general surgical service admitted an equal number, 13 patients or 22.4% each. The plastic surgical service admitted the least number, 10 patients or 17.2%.

Regarding the severity of the burn however, as judged by the length of hospital stay and total number of operative procedures, the pattern was reversed. The patients cared for on the plastic surgical service averaged three operative procedures each and had an average hospital stay of 30.4 days. Those on the general surgical service averaged 1.4 operative procedures each and had an average hospital stay of 16.4 days. Of those patients cared for on the general practice service, the average length of stay was 8.5 days and the number of operative procedures averaged 0.4 per patient. The patients cared for on the pediatric service had an average stay of 5.5 days with no operative procedures.

	No. of patients admitted	% of patients admitted	Average hospital stay	Average number surgical proc.
General Practice	23	38	8.5	0.4
Pediatric	13	22.4	5.5	0
General Surgery	13	22.4	16.4	1.4
Plastic Surgery	10	17.2	30.4	3

The overall average hospital stay for the burned child at this hospital was 12.9 days. Of the 58 patients, 41 were boys and 17 girls. The oldest was 15 years and the youngest 4 months of age. The most common age by far was 2 years. Ten of the 58 patients were 2 years of age. The next most common ages were 3 years (five patients) and 5 years (five patients). The average age was 5.1 years, and the median was 3 years.

To put the overall severity of these burns more in perspective, it was noted that of the twenty patients requiring surgical procedures, nine of the patients were found to have second degree burns and needed only a single operative procedure for debridement. With the exception of two, these patients were all cared for on the general practice service. The remaining eleven patients required an average of 4.5 surgical procedures, all involving skin grafting with one exception. This exception was a mentally retarded child requiring three procedures for debridement and dressing changes, and was cared for on the general practice service. All the remainder in this group were treated by the general and plastic surgeons.

Of interest is the fact that the most extensive pediatric burns were all admitted within the last two years of the hospital's five year existence and were mainly cared for on the plastic surgical service. These cases were most often derived from an agency of the State Government (Division of Services for Crippled Children).

Of the eleven cases classified as severe burns, seven were burned by flame, eight were males. In general, these burns were in the older age group (7-15 years) and were caused by the child's own foolish activity, i.e. throwing gasoline on fires. These severe burns can be tabulated as shown in table at bottom of page.

The sources of all burns were:

Liquid (water, coffee, etc.)	21
Petroleum products	8
Flame	11
Gas Stove	7
Bonfire	2
Matches	1
Candle	1
Vaporizer	5
Explosion	5
Chemical	3
Cooking grease	3
Contact with metals	2
Total	58

The anatomical areas burned were tabulated with the following frequency:

Upper extremity	30
Trunk	25
Face	23
Lower extremity	23
Neck	7
Genitalia	2
Intra oral	1

Summary

The experience with hospitalized burned

Sex	Age	Hospital Stay	No. of Operations	Cause
M	12	76 days	8	Fell into bonfire
M	7	50	8	Threw gasoline on fire
M	3	52	7	Clothing aflame on stove
M	9	65	5	Threw gasoline on fire
M	15	40	5	Threw gasoline on fire
M	12	39	5	Playing with alcohol lamp
M	9 mo.	26	2	Hot grease spilled on patient
M	1	8	2	Boiling water
F	2	34	2	Boiling water
F	7	17	3	Candle (mentally retarded)
F	2	12	2	Boiling water

children in one suburban general hospital covering a five-year period since its opening is reviewed. It was found that the general practice service admitted more pediatric burns than the pediatricians, general surgeons or plastic surgeons. The more serious burns were cared for on the plastic surgical service. The severity of the burns and the frequency of their admission seemed to be increasing with the age of the hospital.

Male children were found to be more frequently burned than female, and older male children to be the most frequently severely burned. The sources of burns and anatomical sites were tabulated.

In general, a high standard of care, with adequate but minimal hospitalization was found in this study. Only three cases were found to be referred to the general or plastic surgery service after treatment had begun in the hospital. The remainder of cases were either admitted directly by the surgeon or were referred at the time of admission to the hospital.

An unproven impression remains in the mind of the author that severely burned children more frequently come from homes with greater marital-social maladjustment than found in the average family. Further, more direct study of this problem has begun.

SURGERY RECONSIDERED

In today's world, tension touches us all. The lay press is filled with medical and pseudomedical articles under the guise of health education. Instead of being health conscious, the public has become disease conscious. The psychoneurotic patient, already susceptible, reads these articles and hurries to the physician's office full of anxiety and apprehension. If, as the figures indicated, 30 of every 100 patients admitted to the hospital and 60% of the patients consulting a physician, have functional problems, it well behooves the physician as well as the specialists to learn to recognize these patients and to make sure that they receive proper medical advice. Surgery at the present time is under some criticism for what some regard as unnecessary operations. Modern anesthesia and supporting care have increased the safety and recovery rate of most surgical procedures. Recovery from an operation does not necessarily carry with it "cure" of the patient. In recent years there has perhaps been a tendency for surgical techniques to receive greater emphasis than surgical judgment. Since the patient with functional disease may actually be made worse by even the most skillful operation, surgical results and the fair name of surgery will both be enhanced by the recognition of functional disease and providing for it the skillful professional care that it requires.

—William J. Engel, M.D., CMD, June 1964.

MANAGEMENT OF UPPER RESPIRATORY DISORDERS WITH A LIQUID SUSTAINED-RELEASE ANTIHISTAMINE

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Upper respiratory disorders with an allergic component as an etiological basis or contributing factor for the over-all symptom complex constitute a significant portion of pediatric practice. The characteristic findings of mucosal edema, hypersecretion of mucus and enlargement of the turbinates are often accompanied by persistent coughing, especially at night.

The clinical manifestations of allergy occur when an antigen(s) stimulate(s) the production of antibodies and the interreaction of these substances results in the release and physiological action of chemical mediators such as histamine, serotonin, acetylcholine, bradykinin, etc.

Elimination of the offender (and there may very well be several allergens) is often unfeasible. Hyposensitization (i.e., increasing the patient's tolerance to an antigen) is an effective method of treatment but when multiple allergens exist this approach is not always successful. Pharmacological agents offer a means of providing prophylactic or symptomatic treatment in those instances where contact avoidance or hyposensitization is impractical.

Many different compounds are available which can be employed clinically as histamine antagonists. Most of them belong in one of seven different chemical classes,¹ and they vary widely in their duration of action,

effectiveness, side effects and toxicity.

When selecting a medication for patients of all ages, established efficacy and side effect propensity are important factors. In children, frequency of administration, flexibility in dosage titration and palatability are particular considerations.

Materials and Methods

The medication was provided as a sustained-release complex of chlorpheniramine tannate suspended in syrup.* The Durabond® Principle employed has been the subject of previous reports.^{2,3} Chlorpheniramine is an established antihistaminic with a wide therapeutic index.⁴

The subjects of the study were 200 children followed in private practice. There were 112 boys and 88 girls. Their ages ranged from two weeks to fifteen years with an average of four years. All subjects had symptoms of an upper respiratory disorder suggesting an allergic diathesis. Each patient had a physical examination and a careful history was obtained. In those instances where there was some question about the presence or absence of allergic factors nasal smears were procured and eosinophil counts conducted.

The medication was administered twice daily at approximately twelve hour intervals. The following dosage schedule was used for initiation of therapy:

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*Each 5 cc teaspoonful contained 4 mg. chlorpheniramine tannate (Durabond® sustained-release preparation) equivalent to 2.5 mg. chlorpheniramine as the maleate salt.

Age Range	Dosage
Less than 1 year.....	½ teaspoonful every 12 hours
1- 6 years	1 teaspoonful every 12 hours
6-11 years	1½ teaspoonsful every 12 hours
11-15 years	2 teaspoonsful every 12 hours

An adjustment of dosage was made when necessary. If the therapeutic response was inadequate and side effects were not a problem, the dosage was increased. When the symptoms were controlled but side effects occurred, a lower dosage was prescribed. The duration of treatment ranged from a few days to over four weeks with an average of about ten days.

It should be emphasized that no concomitant drug therapy (e.g., sulfonamides, antibiotics, antitussives, etc.) was used. In fact, the parents were instructed not to give the children any additional medication including aspirin. It was felt that this procedure had to be followed in order to obtain an unclouded appraisal of the efficacy and side effect properties of the preparation under study.

Results

The children were seen frequently throughout the evaluation. The mothers were questioned at each visit to see if their comments tended to confirm the physician's assessment of improvement. In relief of presenting symptoms, results were considered to be excellent when symptomatic relief was complete. A good result was recorded when there was obvious improvement but incomplete relief. If there was some relief but the child still had definite complaints, the rating was fair. A poor result indicated little or no discernible improvement.

The table below depicts the results:

TABLE

Relief	Excellent	Good	Fair	Poor
Number of Patients	71	89	28	12
Per Cent	35	45	14	6

It will be noted that 80% of the patients obtained good to excellent relief of upper respiratory symptoms. Another 14% ex-

perienced some reduction in symptom intensity. Six per cent demonstrated little or no evident benefit.

Side effects were very infrequent with six reports of drowsiness and one of loose stools for a 3.5 percentage.

Cough was a presenting symptom in 112 patients. Considerable relief ensued drug therapy in 61 patients (54%) and another 31 subjects (28%) had some cough reduction. The antitussive action (probably to a large extent related to a decrease in post-nasal "drip") was particularly helpful in curtailing night-time cough.

The onset of action appeared to be fairly prompt, averaging about thirty minutes. The duration of therapeutic activity was also recorded. Most patients derived a beneficial response for twelve hours after a single dose although a few found that there was a tendency for symptom "break-through" in nine to ten hours after drug ingestion.

Conclusions

Chlorpheniramine tannate as a sustained-release syrup proved to be an allergic etiology.

Cough intensity and frequency were also reduced in a high percentage of cases when this was a presenting symptom.

Administration of the medication was usually trouble free; acceptance by younger patients and their mothers was good.

The onset of action was within the clinically useful range averaging approximately one-half hour. Most patients obtained relief of symptoms for twelve hours from a single dose. In a few cases symptoms tended to recur in nine to ten hours after drug ingestion.

It is the author's opinion that this preparation is a worthwhile addition to the therapeutic armamentarium available for treating children.

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NURSING HOME PLACEMENT: THE PHYSICIAN'S ROLE

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Since 1961 the Illinois Department of Public Health and the Kramer Foundation have been studying the relationships between physicians and nursing homes in Illinois.^{1, 2} Personal interviews have been conducted with 118 randomly selected nursing home administrators and 97 physicians attending patients in these homes. We found that only about one-half of the physicians were usually familiar with the Minimum Standards, Rules and Regulations for Nursing Homes published by the I.D.P.H.³ for the guidance of nursing homes and their attending physicians.

During the past 30 years no scientific articles have been published in the *Illinois Medical Journal* on the care of nursing home patients, although more than 30,000 patients are being cared for in 630 Illinois nursing homes. Accordingly, it would appear useful to provide the physicians of Illinois with excerpts from the Minimum Standards which apply directly to physicians so that a comparison of the regulations can be made with the findings of our surveys.

Nursing homes are medical facilities.

They need (in fact, are required by law) to have their patients under the care of physicians. Nursing homes are expected to obtain necessary medical support, advice, and supervision both before and during the patient's placement. There are many indications that nursing homes do not always get the help from physicians which they need. As a result many homes do not meet satisfactory standards of medical and nursing care. It is crucial that the physician fully accepts his responsibility to help patients and their families reach a proper decision about admission to a nursing home. He then has a further responsibility to make certain that his patient receives good care while in the home.

Definition and Admission Regulations

"A nursing home is . . . maintained for the express or implied purpose of providing care for three or more persons not related to the licensee by blood or marriage to the third consanguinity (second cousins), who, because of *illness* or *physical infirmity*, require *more* services than board, room, laundry, and personal care. Nursing homes shall not expressly nor impliedly restrict their admission to persons sixty years of age or over." (Italics added. Unless otherwise indicated, statements in quotes in this paper are taken from the Minimum Standards, Rules and Regulations for Nursing Homes of the I.D.P.H., reference #3.)

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It can be seen from the definition that the kinds of patients suitable for nursing homes are usually too ill or require too much medical and nursing care to be taken care of in their own homes. Yet most nursing home patients are not in need of the more elaborate and expensive facilities for diagnosis and treatment which a hospital provides. Thus a careful medical evaluation is an essential element in coming to a decision regarding nursing home admission.

Placement of a patient in a nursing home is a complex matter of getting the right patient into the right home at the right time and at the right cost. This usually requires detailed knowledge of the medical and nursing care needs of the patient including family, social and economic situation as well. Each physician should thoroughly familiarize himself with the resources of nursing homes in his area in order that he may be properly informed when faced with this decision. Some homes are better able to care for certain patients than others.⁴ Some may specialize in rehabilitation nursing, some may do particularly well with confused and disoriented patients, others may be especially effective with alert patients who can take part in recreational activities. The physician can learn how to recognize a good home and a competent staff.

The chronically ill or elderly patient should remain in his own home as long as this arrangement is not harmful to him or to his family. Frequently the possibility of placement in a nursing home arises as the result of a crisis in the family. Problems multiply, tensions mount, and finally an intolerable situation develops. The physician must be aware of all other community resources which might be utilized to resolve this crisis and not permit himself to be pressured into making an unwise admission to the nursing home by anxious relatives. Hospital and clinic facilities, homes for the aged, sheltered care homes, and rehabilitation centers should be considered as possible alternatives. The physician should be aware of the services provided by the local full time health department, visiting nurses, home care pro-

grams, adult education for both patients and relatives, and restorative health services which can be carried out in the home such as physical therapy and speech therapy. He should consider referral to information centers such as Central Service for the Chronically Ill in Chicago, Welfare and Relief Agencies which may offer economic assistance, Family Service Associations or similar organizations which provide counseling and case work, sources of legal aid, day care centers, foster home programs, friendly visitors, etc. Counseling with the family's religious advisor may help relieve a crisis so that placement becomes unnecessary.

Many a patient may be kept in his own home if he can receive guidance and retraining so that he can take care of himself with a minimum of help from others. Physical alterations such as removal of thresholds, installation of grab-bars and hand rails, labor saving devices, and assistive gadgets may make the difference between living at home or in an institution. Outpatient psychiatric help for the patient and/or family may permit a resolution to be found so that institutionalization can be avoided without disrupting the family by subjecting its members to intolerable emotional stresses.

"Nursing homes for chronically ill children under 18 years of age shall be used exclusively for children. Children may not be cared for in a home for adults except when special permission is granted by the Department.

"All employees shall have a physical examination before or within forty-eight hours after employment with certification from a licensed physician that they are free of a communicable disease including active tuberculosis.

"No nursing homes shall admit a person requiring prenatal or maternity care."

These provisions of the Minimum Standards are self-explanatory.

Medical Care Requirements in Illinois Nursing Homes

"Every patient shall be under the medical supervision of a physician licensed to practice medicine in Illinois, except pa-

tients in (Christian Science) homes." The survey indicated that all homes were complying with this requirement. One home near the Indiana border has special permission to permit Indiana licensed physicians to practice in the home. The average home has eight attending physicians with a variation in the sample from one to thirty.

There was practically no formal organization of nursing home attending physicians. Only one nursing home out of sixty-six in the pilot study in 1961¹ reported having a formally organized staff which had written regulations and regular meetings. Certainly it would be highly desirable for each nursing home to have a formally organized medical staff with by-laws and regulations and organized meetings at least annually, along the lines which have been established for medical staffs of hospitals. Such a plan would contribute to improved medical care in the home and not place unreasonable demands on the time of an already busy practitioner. In contrast to the survey findings it is interesting to note that when the physicians were asked whether or not a formally organized medical staff was a good idea for a nursing home, 63% gave an unqualified "Yes" and an additional 26% said it was a good idea but impractical.

"Every patient or his family, guardian or the agency responsible for him, shall be allowed a physician of his own choice." Although all nursing homes in the survey reported that the patient has a choice of physician, there are practical considerations which limit the choice. Frequently the patient is from out of town and the previous attending physician is too far away to continue taking care of the patient. One nursing home stated that a house physician treats all patients for a flat fee. Several problems were specifically related to those patients whose care was being paid for by the Illinois Department of Public Aid. Some physicians will not accept the rates that I.D.P.A. pays. Some physicians are not approved by the I.D.P.A. If the physician is some distance from the home, a problem arises since I.D.P.A. will not pay mileage.

Since about one-third of the patients in the surveyed homes are recipients of I.D.P.A. funds, these factors represent a considerable problem in the provision of adequate medical care.

About three-fourths of the nursing home administrators indicated that the present arrangement with their attending physicians was satisfactory. The remainder felt it was only fairly satisfactory or needed improvement.

"Every patient shall have a physical examination prior to or within seventy-two hours after admission to the home. At least annual physical examinations shall be given to all patients and recorded on the patient's record. The physical examinations shall include a statement signed by the physician that the patient is free of a communicable disease including active tuberculosis."

The survey found that completion of a physical examination within seventy-two hours after admission to the home was always performed in fifty percent, usually performed in forty-one percent, occasionally in three percent, and seldom in three percent. Yearly physical examinations were reported as always being performed in forty-seven percent, usually performed, twenty percent, occasionally performed, twelve percent, seldom performed, three percent, and never performed, two percent. In view of the fact that the state law *requires* these admission and annual examinations on all patients, it is clear that not only are state regulations being violated but many nursing home patients are not receiving adequate medical care. The administrators indicated that only seventy percent of the admission physicals and forty-seven percent of the annual follow-up examinations were helpful in guiding the nursing home personnel in the care of the patient.

The Department of Public Health has set up criteria for the admission of patients with inactive tuberculosis to nursing homes. (See below under Communicable Disease Policies.)

"Every home shall arrange for a physician, licensed to practice medicine in Illinois, to be available for emergency calls

when the patient's attending physician is unavailable."

The survey found that physicians can always be reached readily by phone for minor advice in sixty-two percent and usually in thirty-six percent. Visiting promptly in an emergency was reported in every case in seventy-one percent and usually in twenty-six percent. Physicians always had a readily available substitute in sixty-eight percent of the homes, usually had a substitute in twenty-one percent, occasionally in five percent and seldom in two percent. Although statistically this represents a fairly high indication of attending physician cooperation, it is evident that in individual instances emergency medical care is not always available for nursing home patients.

"By the home's licensing date in 1965 there shall be an advisory physician or a medical advisory committee composed of licensed physicians who shall be responsible for advising the administrator on the overall medical management of the patients in the home. This physician or committee shall not be responsible for individual patient care, except for the physician's own patients, but may be the physician who is available for emergency."

Only one-fourth of the homes in the survey fulfilled this requirement. Although the majority of the administrators indicated they were satisfied with their medical advisor, there was more dissatisfaction with his services than with attending physicians. In *Guides for Medical Care in Nursing Homes and Related Facilities*⁵ it is recommended that each home have a medical advisor for matters pertaining to administrative procedures, nursing care, physical or other restorative therapy, special diets, medications, and medical records. The medical director provides advice and support which is essential to the effective administration of a nursing home. He can be especially useful in the development of criteria for selection of new patients, resolving nursing care problems, supervising the day-to-day rehabilitation procedures, the management of especially difficult patients, the teaching of nurses and aides, as

well as liaison with hospitals, other physicians, dentists, and paramedical consultants. The medical director's help in management of problems facing families of the patient may be indispensable in arriving at a successful plan of nursing home care.

Communicable Disease Policies in Nursing Homes

"A home shall assume the responsibility for seeing that necessary precautions are taken and that all the communicable disease rules of the State and Local Health Departments are followed so that there is a minimum danger of transmission of communicable disease.

"The presence of a typhoid carrier among employees or patients shall be reported to the Department immediately upon discovery.

"No home shall knowingly admit a person suffering from tuberculosis or infectious communicable disease. Neither shall such a person so diagnosed after entering a home be permitted to reside permanently in the home. Such an individual when suspected or when diagnosed as such shall be on isolation care in a private room until the family, the guardian, or social worker responsible for the patient places him under adequate care, or the condition becomes non-infectious."

The Division of Tuberculosis Control and Division of Hospitals and Chronic Illness have set up the following criteria for admission of a patient with a history of tuberculosis into a nursing home, sheltered care home, or home for the aged.

"1. No patient may be admitted into a nursing home, sheltered care home or home for the aged who has been in a tuberculosis sanitarium until the inactive status, as defined by the latest classification of the American Thoracic Society, has been reached.

"2. *If admitted less than two years after release from a tuberculosis sanitarium* quarterly X-rays of the chest of this patient will be required and the X-rays must be sent to the referring tuberculosis sanitarium for comparison with previous chest

films. In addition to this, an authenticated sputum specimen must be collected quarterly and submitted for a culture.

"3. Chemotherapy recommended by the sanitarium must be continued for one year after discharge from a sanitarium and any other medical regime that may be recommended by the sanitarium must be followed as ordered on the 'inactive status patients.'

"4. *If a patient has been in a tuberculosis sanitarium and has been dismissed two or more years previous to admission to the nursing home, sheltered care home or home for the aged, that patient can be admitted to the institution provided a chest X-ray is taken before admission and compared with the X-rays in the tuberculosis sanitarium, and that prior to admission to the institution an authenticated sputum specimen is taken for a culture and found to be negative. This patient then should have at least an annual X-ray, unless recommended otherwise by the tuberculosis sanitarium.*

"5. Any individual known to have had tuberculosis should have a chest X-ray and an authenticated sputum examination within a week after the onset of any upper respiratory infection. The chest X-ray should be sent to the tuberculosis sanitarium for comparison with previous films and the authenticated sputum specimen sent to the State laboratory for culture.⁶

"The occurrence of an infectious disease, or food poisoning or dysentery, shall be reported immediately to the local health department and to the Illinois Department of Public Health.

"An employee found to have an infectious disease or suspected of having an infectious disease shall not be on duty until such time as the disease is no longer contagious or until found to be not infectious."

These policies are self-explanatory and represent good public health practice. There was no indication in the survey that communicable diseases have as yet created a serious problem for nursing homes.

Mental Illness Policies

"A home shall not accept nor keep patients who are destructive of property or themselves, who continually disturb others, who show hostility to others, or who have similar characteristics of serious mental or emotional problems. A home may take care of mental defectives and of mild senile cases manifesting mild memory changes and slight confusion.

"If a patient becomes disturbed and unmanageable, he should be removed from the home within a period of time not exceeding five days. During the disturbed state, a patient shall receive management for same only under the direction of his physician. If the patient does not respond to the treatment provided by the physician within the five day period, he should be removed from the home.

"Restraints are defined as the application of any device to any part of the body which will inhibit the movement of that part of the body of a patient. A support of extremities for intravenous infusions, treatment of a fracture or sprain, etc., are not considered restraints. Anklets, wristlets, restraining sheets, or any device which limits the movement of the patient are considered restraints.

"Restraints shall be used only in emergency and only on a physician's order. No such order shall be valid for more than twenty-four hours. The physician's order shall be in writing and shall contain the patient's name, date, and time of order, and reason for restraint.

"The patient under restraint shall have his position changed in bed and restraints removed for a few minutes at approximately two hour intervals. This should be recorded in the nurse's notes on the patient's chart.

"A wide band (minimum width of twelve inches) or sheet may be applied around

the waist of patients to *prevent falling* out of bed or a chair and for no other purpose. This must be ordered by the physician, stating the reason for the support. There should be a new order once a month if continuous precautions are needed.

"No form of seclusion shall be permitted even if the patient desires it. (Seclusion is the retention of patient in a locked room.)

"No nursing home shall keep for care, custody, treatment, detention and training on either an in-patient or out-patient basis, any mentally ill person except those on conditional discharge under supervision of State Hospitals. (See Illinois revised statutes, Chapter 91½, Paragraphs 1-1, 17-1.)

"A license may be revoked, or a renewal thereof denied for the following reasons: cruelty or indifference to the welfare of the resident; failure to provide a patient with care and supervision he requires; or the infliction of mental or physical abuse. Restraining a patient except as above is defined as cruelty to a patient. Striking, slapping, hitting, or withholding food as punishment is cruel treatment." (There are other reasons for license revocation not specifically related to mental health policies.)

Seriously disturbed people should not be managed in a nursing home if they need mental hospital treatment. This differentiation as to where a patient should be treated cannot be made on the basis of either a physical or a psychiatric diagnosis. The decision regarding placement of the disturbed patient depends on how difficult his behavior is, how dangerous to himself and others, and the likelihood that treatment by available personnel will be successful. In addition to the types of patients mentioned above, other individuals who may need mental hospital treatment include those who have made serious homicidal threats, who have made repeated sexual advances toward children, who demonstrate persistent sexual exhibitionism, combativeness, uncontrolled roaming with falling, getting lost, or having accidents, persons who are very noisy over

a prolonged period, markedly agitated, or severely untidy. Suicidal or belligerently paranoid patients should not be in a nursing home unless psychiatric advice is readily available.

Consultation with the attending physician, medical director, or a psychiatrist is usually necessary to determine whether or not a patient would be better managed in a nursing home or a mental hospital. With judicious use of the many available tranquilizers and anti-depressants in addition to the practical application of modern concepts of the therapeutic community, many borderline emotionally and mentally disturbed patients with personality and behavior changes are being treated in nursing homes rather than being transferred to mental hospitals. This is an area where the physician's experience and judgment are crucial to the proper functioning of the nursing home.

Physician's Orders and Medical Records

"... up-to-date nursing care program for each patient based on individual need which shall include physician's orders.

"Each patient shall be up and out of bed as much as his condition warrants unless his attending physician states in writing on the physician's order form that he must remain in bed.

"Medical examination record which shall include admission diagnosis, physical findings, statement that the patient is free of a communicable disease including active tuberculosis, and shall be signed and dated by the physician. This shall be completed prior to admission or within seventy-two hours after admission.

"All subsequent medical examinations shall be recorded in the same or similar type of record, dated and signed by the physician."

Written progress notes at each visit were always performed by physicians in the survey about half the time. Only about two-thirds of the orders were signed.

"Discharge information record which shall be completed immediately after the patient leaves the home indicating date, time, how and condition (death, transfer

to hospital, home, etc.)”

Nearly one-half of the homes reported that physicians only occasionally or never had the charts of patients completed and signed out at the time of discharge. Thus a great deal of clinically useful, scientific information may be lost to anyone studying nursing home care, to say nothing of missed opportunities for physicians to sharpen their diagnostic and treatment skills with the geriatric patient.

“Physician’s order record shall contain orders for all medications, treatments, diets and activities of the patient, i.e. bed-fastness, chair, walking, etc. The physician may use this form to order aids to daily living activities or use a special form for this order. All entries shall be dated and signed by the attending physician.

“Whenever a medicine, treatment or modified diet is discontinued, this shall be in writing, dated and signed by the physician. Telephone order forms which shall contain the date, physician’s order, signature of the nurse taking the order and signature of the physician to be attached to the physician’s order record in lieu of his written order. (See below.)

“All medications and treatments shall be given only upon written, dated, and signed order of the patient’s attending physician or dentist. This order shall be on the physician’s order sheet.”

The administrators reported that only about three-fourths of their physician’s orders were of practical use to them in administering medications or carrying out rehabilitation.

“When medications and treatments are to be discontinued the physician shall so indicate in writing on the physician’s order sheet unless the original order limited the number of medications or treatments to be given.

“Telephone orders given for a medication or treatment shall be written on a ‘telephone order form’ which is made out in duplicate, dated and signed by the nurse taking the order. If the physician visits the home within twelve hours after the order is taken, he may sign this form

or write and sign this order on the physician’s order record. If he does not visit the home within twelve hours, the original shall be sent or taken to him for his approval and signature and returned to the home within seventy-two hours. A duplicate copy is to be used by the nurse to carry out the instructions and may be destroyed when the original is returned and attached to the physician’s order record.

“All medications, except narcotics, belonging to a patient who has left the home shall be destroyed or otherwise disposed of at the discretion of the patient’s physician.

“A home may stock only drugs which are regularly available without prescription at a commercial pharmacy, i.e. cough syrup, laxatives, analgesics, etc. These shall only be given to a patient upon written order of the physician or dentist . . .

“Modified diets should be provided for patients as ordered in writing by the physician.

“There should be a first aid kit or emergency box in every home. It shall contain band-aids, sterile 4 x 4 gauze dressings, bandage scissors, tape, sling, burn ointment and any other equipment deemed necessary by the physicians visiting the home.”

Although the majority of attending physicians do fulfill some of their responsibilities with regard to medical orders, the many times they fail to do so create serious problems for nursing home personnel in their efforts to provide proper patient care.

In-Service Training

“Every home shall develop a method of in-service training for non-professional personnel who are performing nursing to be assured that they understand the proper method of carrying out necessary procedures. No nursing personnel shall perform duties for which they have not had the proper training.”

The survey revealed that teaching nursing personnel is the most poorly performed of all physician duties in the homes. Only fifteen percent of the administrators reported

that physicians always performed this function; in only twenty-three percent of the homes did the attending physicians take part in training of nursing personnel more than occasionally. Medical advisors were more active, being involved in teaching nurses in thirty-five percent of the homes, although this was by far the least often performed activity which was investigated.

It is true that the majority of nursing techniques are and should be taught to aides by supervisory nurses. However, every training program should have the benefit of the experience of the attending physicians in order that the staff working directly with the patients may have a better understanding of what is wrong and what the purpose of their treatments may be. The majority of our professional personnel were not well indoctrinated in principles of rehabilitation which have only in recent years become a part of medical and nursing education. The vital importance of understanding the psychological aspects of the care of chronically ill patients must be transmitted to all those who work with patients, if treatment is going to be successful. It is the physician's responsibility to take the lead in providing this instruction. Time and again it has been demonstrated that patient care improves in institutions where the attending physicians and the medical director take an active part in both bedside and informal classroom teaching. We cannot possibly be providing proper medical care in a situation where the staff who provides the most care for the patient has received the least amount of education and training.

Other Medical Functions

It should be emphasized that we are quoting from *Minimum Standards* for nursing homes. There are many other medical services which are highly desirable but which have not yet been required by the Department of Public Health. For example, only thirty-three percent of the homes provide yearly chest X-rays for their patients. Only fifty-eight percent give influenza immunization, a procedure recommended by the Surgeon General for all the chronically

disabled. Only fifty-five percent have made arrangements for blood counts and stool examinations. Only thirty-three percent provide for V.D. tests.

There are many areas where services by physicians need a good deal of improvement and which are difficult to enforce through legislation. For instance, only fifty-six percent of physicians properly prepare their patients for admission to the nursing home. Only two-thirds of attending physicians inform the family and others when a change in the patient's condition warrants it. In many homes the physicians did not visit as often as necessary. Doctors are often slow to refer their patients to the dentist, psychiatrist, speech therapist, religious advisor, or other paramedical therapist. Administrators report that occasionally the attending physician shows less and less interest in his patient with visits farther and farther apart until eventually the patient can hardly be said to be under a physician's care.

One of the most common problems which nursing home administrators have is that the attending physician fails to understand the patient's emotional needs. Only twenty-nine percent of the homes felt that the attending physicians were aware of and took into consideration the psychological aspects of their patients. Only thirty-nine percent felt that the doctors really understood the problems that nursing homes have in caring for these difficult, elderly and chronically ill individuals. A number of administrators stated that many physicians really did not understand rehabilitation procedures, writing such orders as "physical therapy daily" without specifying what kind of therapy was to be given, by whom, how often, for how long, under what circumstances, and with no instructions as to follow-up and adjustment of treatment as the patient progressed.

Conclusions

Nursing homes which serve patients who are too ill or too old to be cared for in their own homes and who do not require the specialized services of a hospital will be an

integral part of our medical facilities as far as we can project into the future. The six hundred and thirty nursing homes in Illinois which care for more than thirty thousand patients will continue to grow in proportion to the increase in our aged population. Nearly all these patients have clinically significant physical and mental illness in addition to complicated family, social and economic stresses. In order that these patients receive proper medical care, it is essential that physicians take a more active and responsible role in determining and carrying out nursing home medical policies.

Recent surveys of nursing home administrators and their attending physicians reveal that many nursing home patients do not even receive a minimum standard of medical service as required by law. Many other aspects of medical care which are professionally desirable, if not legally mandatory, are given inadequate attention by physicians. Nursing home administrators, public health officials, and many others including the general public are also partially responsible for this failure. This does not relieve physicians from responsibility for their aged and chronically ill patients in nursing homes.

Physicians need to examine their own prejudices against providing adequate care for these patients. We must take an active role in insisting upon higher standards of

medical service. If physicians take the lead, nursing home personnel will follow. Physicians who have embarked upon training programs for nursing home staffs find them eager to learn, willing to admit their deficiencies, and in nearly all instances capable of modifying their techniques and attitudes. They are eager for the physician's leadership in providing better care for the physical and emotional needs of their chronically ill and aging patients.

Acknowledgments

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INGUINAL HERNIA REPAIR

Stainless steel mesh, when properly used in the repair of direct and indirect inguinal hernias by placement in the preperitoneal space and by suturing in position with No. 3-0 stainless steel wire, does not produce pain or rejection and does not result in fragmentation. Its use in this manner has not been associated, up to the time of writing, with recurrence in any of the direct and indirect hernias repaired from 1956 through 1962. These results seem logical, since the blood supply in the preperitoneal space is sufficiently abundant to foster rapid fibrous interlacing in the mesh and since this level of the abdominal wall is subject to much less motion than are more superficial levels. *The Journal of the International College of Surgeons*, October, 1964.

On October 21, 1926, Harry Houdin, professionally known as Houdini, was in Montreal performing at the Princess Theatre.⁵ During this engagement, he gave a lecture before the students of McGill University and stated that as a result of clean living and regular exercise, he could permit the strongest man to aim a blow at any portion of his body above the belt, except the face. A young student who participated in boxing asked Houdini if he could punch him with all his might. Houdini said "Yes" and the young man punched him in the epigastrium. Houdini gasped and fell back and said "Not that way—I've got to get set for it." He then braced himself and asked the student to punch him again and Houdini's abdomen was "like an oak plank." Later Houdini rubbed his abdomen but continued his performances. He went to Detroit with a temperature of 102°, was told that he had appendicitis, refused to do anything about it, but was operated on October 25 with a temperature of 104°. Drains were placed but he died October 31, 1926 of peritonitis.

I am unable to verify some of the details but I was informed a few years later, that the peritonitis was induced by pancreatic damage. Fat necrosis was mentioned.

Pancreatic injury is not common but can occur from penetrating or blunt trauma.

Penetrating Wounds

Stab wounds, bullets, industrial missiles have all been reported and can cause damage to the pancreas and other organs. The management of penetrating wounds is decided readily as prompt surgical intervention is indicated as soon as the patient can be operated with some degree of safety. If there are large vessel, bowel, stomach or liver wounds, these injuries must be treated. It is probable that in most penetrating wounds, vascular instruments should be ready so that repair of the vena cava, portal vein or other important structures can be done without delay.

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TRAUMATIC INJURIES OF THE PANCREAS AND THE MANAGEMENT OF TRAUMATIC PANCREATIC PSEUDOCYSTS

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We have been informed in the daily press and otherwise that Lee Harvey Oswald, the assassin of President Kennedy, sustained multiple injuries including pancreatic lacerations.

The management of the pancreatic wound should be cautious. In general, suture of the pancreas should be avoided if at all possible and although the pancreas is an extremely vascular organ, it is surprising how hemostasis can be obtained by placing a pack on the damaged pancreas at the point of bleeding and placing the flat of an assistant's hand on that pack to remain firmly for ten minutes or more while you are doing some other procedure in the abdomen. The individual whose hand is placed on the pancreas to act as an hemostatic pack, is to remain there and not move until the surgeon returns to that area. It is a mistake



Figure 1. Blow to epigastrium compressing pancreas against vertebral column.

to begin working on the pancreas hastily and it is gratifying to see how much can be done by using pressure hemastasis. When the pack is removed it should be removed gently so that hemastasis will not be disturbed. One can also use Absorbable Hemostat (Surgicel®) or absorbable Gelatin Sponge (Gelfoam®). If a vessel is still bleeding and can be seen, it should be ligated without including pancreatic tissue in the suture. The more suturing and sewing that is done on the pancreas, the more pancreatic necrosis occurs and the more opportunity for acute hemorrhagic pancreatitis is provided.

If we realize that pancreatitis is due to duct obstruction plus activation of trypsinogen to trypsin by enterokinase and that enterokinase is not only in the intestinal tract but that there is a small amount of it in the blood stream we will realize that hematoma and a large amount of necrotic material will provide the combination necessary to produce fatal pancreatitis.

If the pancreatic bleeding can be controlled without suturing and the duct is not visible, sump drainage down to the pancreas brought out through stab wounds on both

sides of the abdomen, should be provided. Baker et al¹ have found in a small series of cases that omission of drainage has resulted in high mortality. Penrose drains are not enough and sump drainage should be employed. If drainage is adequate the development of pseudocyst is not likely. However, if a pseudocyst forms it should be treated, preferably six weeks later, by some form of internal drainage.⁷

Blunt Non-Penetrating Wounds

Blunt wounds are due to a moderately sharp object striking the victim in the epigastrium (Figure 1). It has been stated in some discussions that the blow does more damage if the patient is bent forward as abdominal muscles are somewhat relaxed. A number of these occur in children striking the handlebars in bicycle accidents. Violent tackles in football with an elbow or shoulder striking the abdomen can also cause the injury. In our modern age the pancreas may be caught between the steering wheel and the vertebral column in collisions. This injury to the pancreas may be contusion, laceration or in a fair number of

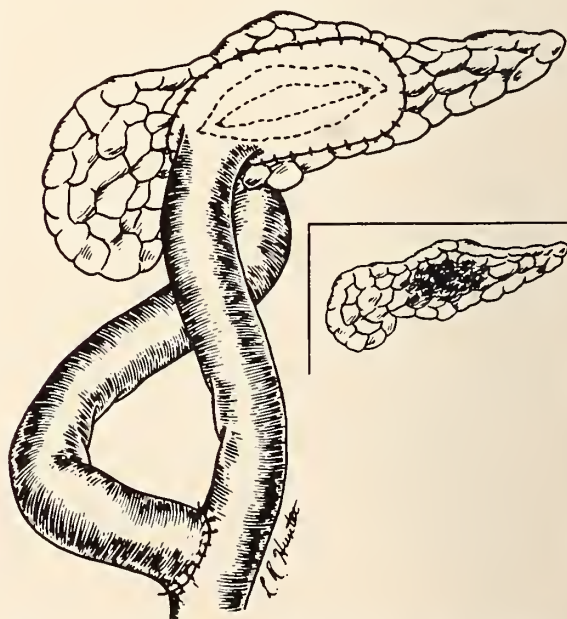


Figure 2. Insert indicates macerated and lacerated pancreatic tissue which should be removed until duct is exposed. Longitudinal pancreaticojejunostomy with opened jejunum over the open pancreas as Roux-en-Y reconstruction is shown.

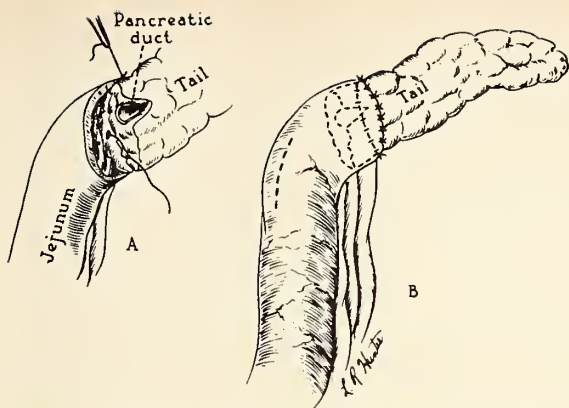


Figure 3. Double pancreaticojejunostomy for divided pancreas. A—distal pancreas implanted in distal limb of Roux-en-Y jejunum. B—completed anastomosis of distal pancreas. Dotted line on bowel shows site of proximal pancreas implantation.

cases, actual fracture of the pancreas with complete division. This may occur without splenic vein or artery injury and can only be suspected pre-operatively.

With blunt injury to the abdomen we have found that peritoneal taps are of great value and should be used almost routinely. A negative tap is not significant but fluid obtained from a peritoneal tap should be analyzed for amylase and blood. With a blunt blow to the abdomen the recognition of the extent of injury will depend on the peritoneal tap, symptoms and the other injuries that have occurred. In injuries to the aorta, vena cava or other large vessels the dilemma is soon resolved because immediate surgery is indicated and the pancreas can be handled by the most expeditious manner after performing the necessary vascular repairs. If the stomach and colon are injured peritonitis and shock will be present and the peritoneal tap will in many cases help one decide whether to operate or not. With pancreatic injury without other organ injuries, the need for immediate surgery is reduced and one has some time to analyze the problem. The blood amylase and urine amylase are usually not decisive in the early hours. If there is a marked change in the amylase level of the blood or urine, the need for surgery is more apparent. One can observe a case that is not deteriorating and whose pulse and temperature are not rising and who

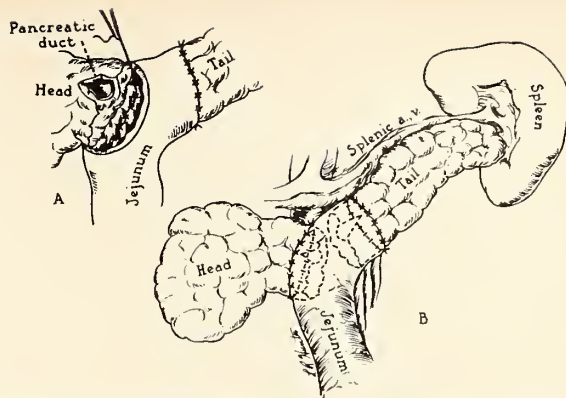


Figure 4. Double pancreaticojejunostomy. A—divided proximal pancreas being implanted in jejunum. B—completion of implantations.

seems to be responding to conservative management. Conservative management should include calcium intravenously, blood, plasma or albumin and nasogastric aspiration. I do not advise the use of anti-cholinergic drugs in suspected pancreatic injury.

If one is in doubt, I believe it is advisable to open the abdomen and settle the question. Missing an injury to the duodenum or bowel is so serious that it is better to take a look than to wait and see.

The pancreas is easily exposed by dividing the gastrocolic omentum distal to the gastroepiploic vessels. This necessitates only about 3 or 4 vessels being ligated. By elevating the stomach one exposes the entire length of pancreas.

If there is hematoma in the pancreas it is best to incise into the hematoma if it is just under the capsule. One must provide adequate drainage and it is important that at least two sump type drains be used and several other Penrose drains should be placed down to the pancreas so that the entire length of the pancreas will have adequate drainage.² These drains should then be brought out through stab wounds. If the tail of the pancreas has been divided it is probable that the spleen will have to be removed with the divided tail of pancreas. The open end of the pancreas should be closed by careful fine suturing. In such a situation, the area of pancreatic tail and splenic bed should be drained by Penrose drains. It is probable that in some cases

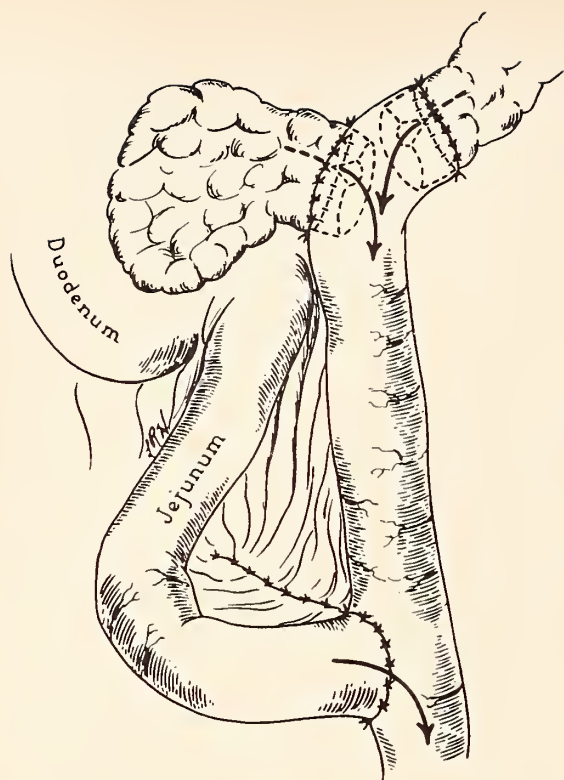


Figure 5. Double pancreaticojejunostomy with Roux-en-Y reconstruction. Jejunum to pancreas should be retro-colic.

one might choose pancreaticojejunostomy by the Roux-en-Y method. Individuals who have chronic pancreatitis seem to have a surprising number of abdominal injuries, both penetrating and blunt and this should be kept in mind.^{3, 8}

If the head of the pancreas has been badly contused and torn, the hemorrhage should be stopped by pressure, using a pack and an assistant's hand for at least ten minutes. One can be preparing stab wounds and putting in drains during this time. This "laying on of hands" accomplishes a great deal in pancreatic bleeding. The previously mentioned absorbable hemostatic agents are to be used if needed. If the anterior tissue of the pancreas is badly bruised, it should be removed and the duct exposed, opened more widely and a pancreaticojejunostomy as shown in Figure 2 should be done.

If the body of the pancreas has been divided (this is a fairly common injury), one should perform a pancreaticojejunostomy in one of several ways but I advise the

method shown in Figures 3, 4 and 5. It is important that the open ends of the pancreatic duct be split open as shown to make sure that the pancreatic juice can readily drain out of the duct. The jejunum is then brought up retrocolically and a double pancreaticojejunostomy as shown in the diagram is performed. There have been two reports of pancreaticojejunostomy^{1, 6} for divided pancreas but in both cases the head end of the pancreas was closed off by suture. I believe it is better to adequately drain the pancreas in the manner I have shown.

Sphincterotomy has been recommended² but the method outlined accomplishes more certain adequate drainage.

Pancreatic Pseudocyst Management

Traumatic pseudocysts constitute 10 to 13% of pseudocysts. If conservative treatment has been employed or a pancreatic pseudocyst has developed following abdominal exploration, the later management becomes important and can be easily performed. If the wall of the pseudocyst is thin and will not support sutures, it is imperative that marsupialization or adequate complete drainage of the pseudocyst be performed using sump or multiple Penrose drains. It is not essential to suture the pseudocyst to the anterior abdominal wall. Adequate drainage is quite satisfactory.

If the wall of the pseudocyst is a substantial one some form of internal drainage should be performed. This may be pancreatic cystogastrostomy, cystojejunostomy using the Roux-en-Y principle or pancreaticocystoduodenostomy.⁷ It is important that the pseudocyst be aspirated before performing any anastomotic procedure. Aneurysms have been mistaken for pseudocysts. In doing a cystojejunostomy one should use the Roux-en-Y principle as side-to-side cystojejunostomy has not been a satisfactory procedure. Pancreatic pseudocysts cannot be removed. The choice of procedure depends on the anatomy and the ease with which one method can be used over another. It is important to drain the area by use of

stab wound Penrose drains following the procedure.

In most abdominal trauma cases particularly where a major abdominal procedure has been necessary, a tube gastrostomy is a useful procedure and if one is dubious about the integrity of the anastomosis, or has divided the jejunum he should use a catheter that will adequately drain the duodenum of bile and pancreatic juice (Figure 6). Electrolyte loss must be kept in mind if this is done. The comfort of a tube gastrostomy following an abdominal operation is so important in severe injuries that the presence of a nasogastric tube is almost cruel to a person who is badly hurt and requires all the help he can get.⁴ The pulmonary complications due to the prolonged use of nasogastric tubes make tube gastrostomy almost mandatory.

Summary

1. Injuries of the pancreas result from either penetrating or blunt wounds of the epigastrium.

2. Penetrating wounds should be managed by surgical intervention and the pancreatic damage should be treated by the least traumatic and simplest method possible.

3. Pancreatic damage should be handled with extreme care avoiding mass suturing and further surgical trauma. Hemostasis should be accomplished by packing at the operating table with removal of the pack before the abdomen is closed.

4. Internal drainage of divided pancreatic tissue should be accomplished whenever the condition warrants. Pancreatic juice in the intestinal tract constitutes normal physiology. Pancreatic juice in the peritoneal cavity is extremely dangerous.

5. Sump drainage is indicated in most cases but drainage of some form is indicated in all cases of pancreatic injury. When in doubt, drain the pancreatic area.

6. The different methods of traumatic pancreatic pseudocyst drainage have been

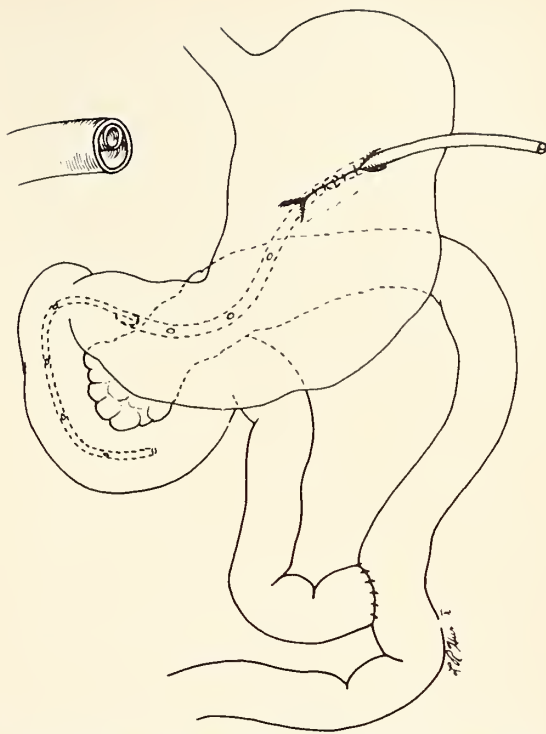


Figure 6. Insert shows double lumen silicone rubber tubing as used in tube gastrostomy and duodenostomy. Figure shows preparation of tube so that small portion with numerous holes is in the duodenum and the large portion with numerous holes is used as a gastrostomy. The tube is brought out through a stab wound. Drainage is quite adequate by gravity only, suction is not necessary.

discussed and in general, internal drainage is to be recommended rather than marsupialization or external drainage.

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CASE REPORT

ANEURYSM OF THE COMMON HEPATIC ARTERY

Victor R. Jablokow, M.D. and

Edward J. Fesco, M.D./chicago

Aneurysm of the hepatic artery is an unusual entity.

In review of the literature in 1959, Browning et al¹ cited 121 cases and added two of their own.

Nineteen more cases have been reported since that time.²⁻¹⁷

The aneurysm may be intrahepatic in location or involve extrahepatic branches of hepatic artery.

The diagnosis during the life is important because untreated aneurysms have poor prognosis and rupture occurs in about 80 per cent of the reported cases (Jontz).⁹ Many of the reported cases have been found at post mortem examination.

Since the advance of the contrast angiography the correct diagnosis is being made more frequently before surgery or during exploratory laparotomy.

Case Report

A 71 year old white male was admitted to the Veterans Administration Hospital, Hines, Illinois, in uremia because of chronic glomerulonephritis, diagnosed three years previously.

The patient was a truck driver who worked until a year prior to admission.

His family history was non-contributory.

The Department of Pathology, Veterans Administration Hospital, Hines, Illinois.

In the last three years he was hospitalized on several occasions in other hospitals for treatment of glomerulonephritis. He was treated with steroids for the past year. Lately he was complaining of epistaxis, which tended to be constant but minimal. During the last two years he had received 24 blood transfusions, five of which were administered during the past month.

Patient had appendectomy 24 years previously.

Physical examination showed a well developed, well nourished male in no acute distress.

Skin, nail beds, and conjunctivae were pale. Examination of the nose revealed presence of a blood clot in the left nasal cavity. Lungs were clear to percussion and auscultation. Heart showed an occasional premature ventricular contraction. No murmurs or thrills were present. Liver edge was felt one finger below the right costal margin. No peripheral edema was present and peripheral pulses showed no abnormalities. His laboratory data were as follows:

Repeated urinalysis showed specific gravity ranging from 1.005 to 1.015. All specimens showed 4+ albuminuria, few to 10 WBC per high-power field, 5 to many RBC, and presence of granular casts. Blood count on admission was: WBC 5,900 with 82 per cent neutrophils and 18 per cent lympho-

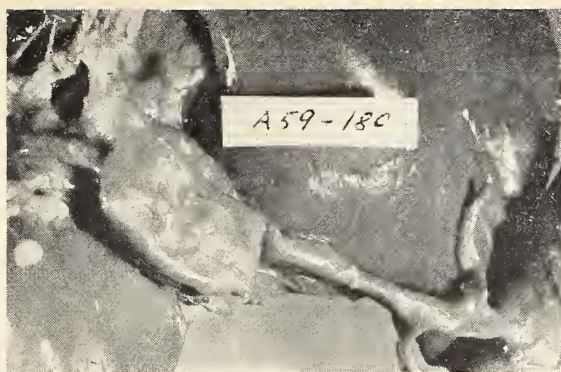


Figure 1. General view of the aneurysm involving common hepatic artery.

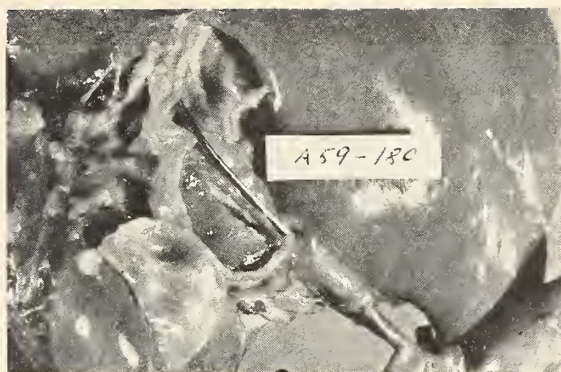


Figure 2. Aneurysm open and blood clot evacuated. The aneurysm has a thin wall. Probe is seen in the lumen of the aneurysm.

cytes. It was essentially the same on subsequent examinations. Hemoglobin was 11.5 grams. It ranged from 11.5 to 9.14 grams. Hematocrit was 32 per cent and RBC 3,250,000. Prothrombin time, bleeding time, coagulation time were all within normal limits. Serology was non-reactive.

Initial non-protein nitrogen was 70 mg. per cent but then rose to 190, and a week before death was 220. Blood Urea Nitrogen was 150.4 mg. per cent. Creatinine was 10.7 mg. per cent. Chlorides from 106 to 79 m Eq. per liter. Sodium from 125 to 113 m Eq. per liter. Potassium fluctuated from 3.6 to 4.65 m Eq. per liter. Calcium was 4.3 m Eq. per liter (highest determination). Phosphorus ranged from 5.3 to 7.3 m Eq. per liter. Chest roentgenograms and electrocardiograms were essentially negative. His blood pressure ranged from 140/80 to 185/95. Temperature showed only slight elevations. Hospital course was characterized by tiredness, easy fatigability, pallor and diminishing appetite. Two weeks before death he developed acute urinary retention which required indwelling catheter. His course was progressively downhill after that and he expired 45 days after admission.

Autopsy Findings

At autopsy an aneurysm of the common hepatic artery was found (Figure 1). It measured 2.5 cm. in greatest diameter and 4.7 cm. in length. The external surface was smooth. No perforations were present.

The aneurysmal sac contained old blood clot partially adherent to the wall. The

lumen, however, was patent and probe could be easily passed into the right and left branches of the hepatic artery. Arteriosclerotic changes were present in the wall of the aneurysm and branches of the hepatic artery.

The gall bladder was free of stones. A simple cyst (3 cm. in diameter) with smooth lining, filled with clear yellow fluid was found near caudate lobe of the liver. It had no connection to aneurysm.

Figure 2 shows closer view of the aneurysm.

Figure 3 shows exact position of the aneurysm.

The rest of the autopsy showed contracted kidneys of glomerulonephritis and generalized arteriosclerosis.

Discussion

The diagnosis of the hepatic artery pre-

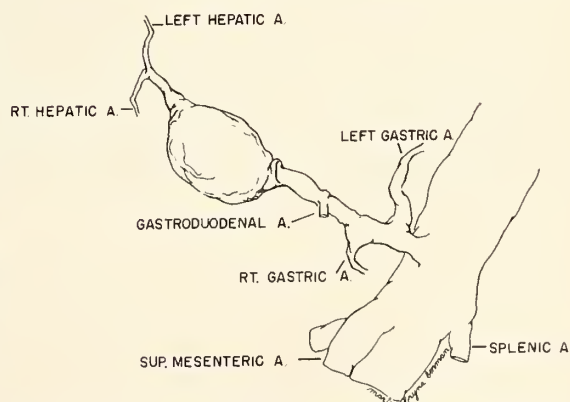


Figure 3. Sketch to show relationships of the hepatic artery with aneurysm and other arterial branches.

operatively is difficult but is being done more frequently since the advance of angiography. The diagnosis during the life is important because many of the aneurysms rupture with fatal results.

Less than 25 cases have been successfully treated surgically (Zeppa).¹⁷

Summary

A case of common hepatic artery aneurysm is presented.

The aneurysm was asymptomatic and was discovered at autopsy.

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THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

This 82-year-old Negro female complained of increasing pain radiating across the abdomen and some weakness in both legs. This was first noted about one year previously.

Physical examination revealed a patient in good physical condition for her stated age. Some tenderness was elicited over the upper lumbar spine, and an ill-defined mass was felt abdominally. Motor weakness was present in both lower extremities with decreased patellar reflexes.

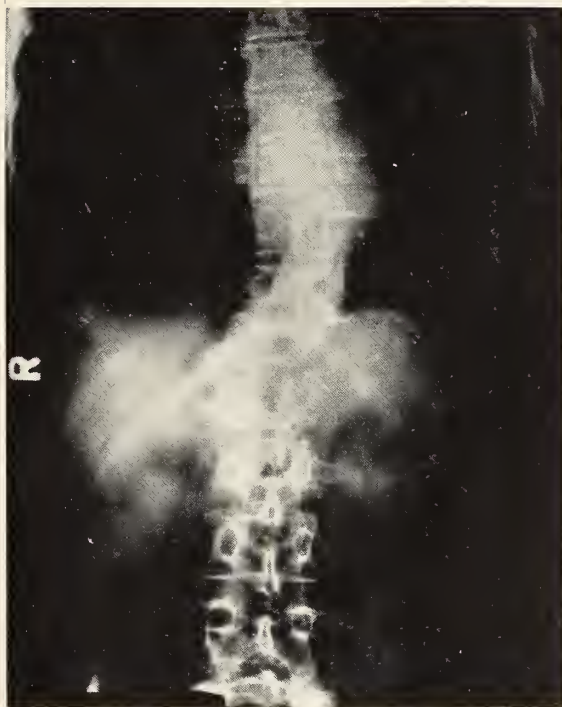


Figure 1



Figure 2

What is your diagnosis?

- 1) Retroperitoneal fibrosarcoma
- 2) Tuberculosis of D-12 and L-1
- 3) Abdominal aneurysm
- 4) Metastatic osteolytic metastasis of bone

(answer on next page)

DIAGNOSIS AND
DISCUSSION

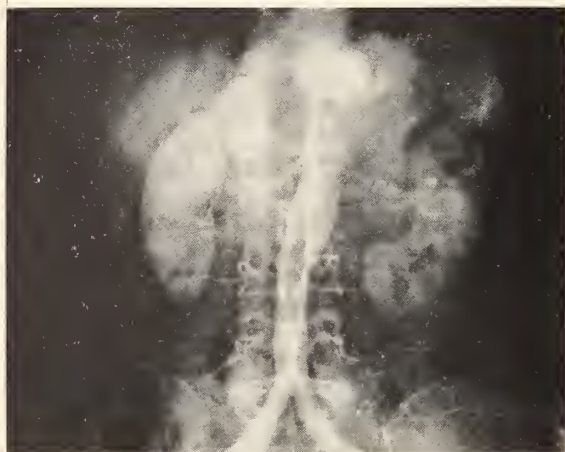


Figure 3

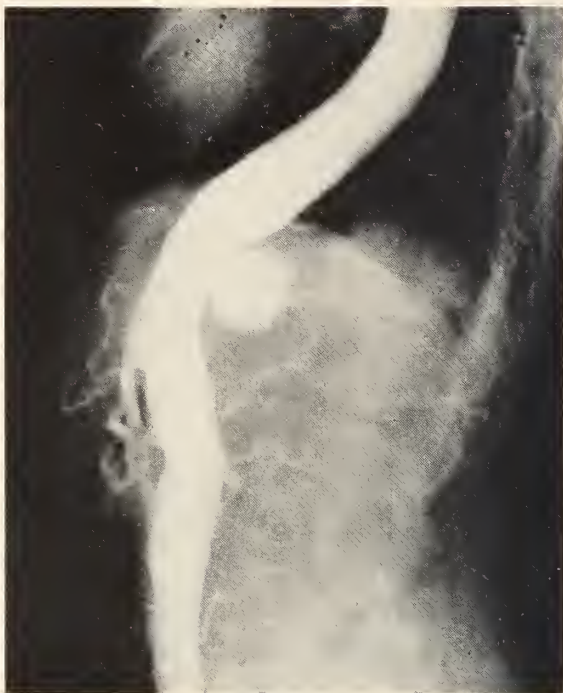


Figure 4

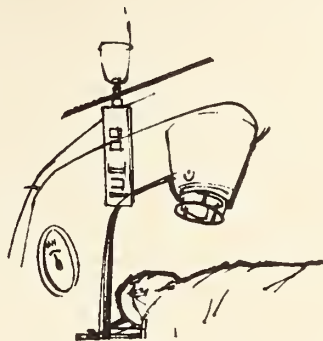
Diagnosis: Abdominal aneurysm.

Films of the lumbar spine reveal extrinsic destruction of the left lateral and anterior bodies and pedicles of D-12 and L-1 by an extrinsic mass which extends under the medial leaf of the left hemidiaphragm.

A catheter was inserted into the right femoral artery up to the level of D-12, and 50 cc. of Conray 400 was injected. (Figs. 3 & 4). The nature of the mass is now readily evident as an aneurysm of the abdominal aorta with a large, non-opacified clot.

Erosive changes of the spine resulting from pulsating clot-filled aneurysm with destruction have been reported many times previously. The direct visualization of the changes with aortography add a new dimension to the diagnosis and understanding of this condition.

Medical Progress



HARVEY KRAVITZ M.D./progress editor

RECENT ADVANCES IN

REPRODUCTIVE ENDOCRINOLOGY

Jay J. Gold, M.D., F.A.C.P./chicago

Reproduction is, of course, as old as the beginnings of life on this planet. Evolution has increased its complexity and modus operandi and has introduced a specific endocrine relationship. Reproductive endocrinology in its crudest forms goes back many years, but the relationship of the pituitary and the gonads was not really appreciated until the early 1900's. In the 1930's, steroid chemistry and its relationship began to emerge but the greatest boost to steroid chemistry and endocrinology came with the isolation of cortisone and its eventual fabrication. Not too long thereafter, great changes in steroid chemistry as related to reproductive endocrinology appeared, e.g., derivatives of progesterone and testosterone with predictable progestational activity for therapeutic use; greater knowl-

edge of estrogen metabolism; the relationship of adrenal dysfunction to gonadal dysfunction; greater knowledge of the ovarian pathophysiology in the bilateral polycystic ovary syndrome and the prominence of testosterone production in the hirsute and/or infertile female.

Without going into complex detail, it was found that several forms of the adrenogenital syndrome existed¹ which are due to various enzyme deficiencies—relative or virtually absolute. For example—in the normal synthesis of cortisol (hydrocortisone or compound F) by the adrenal, such enzymes as 3-beta-hydroxysteroid dehydrogenase, 17-alpha-hydroxylase, 11-beta-hydroxylase and 21-hydroxylase exert an essential function. If any of these enzymes are deficient, precursor compounds accumulate which may have undesirable physiologic effects themselves or these compounds may be metabolized to such undesirable compounds. The classic form of the adrenogen-

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ital syndrome is associated with a relative 21-hydroxylase deficiency and the salt-losing form with a more complete deficiency of the same enzyme. The hypertensive variant has an 11-beta-hydroxylase deficiency, etc. Each form has the characteristics of the adrenogenital syndrome but with additional changes depending on the enzyme deficit. Therapy with the hormone that is lacking—e.g., cortisol or its equivalent, suppresses the disordered and hyperactive adrenal and at the same time provides the very hormone that the adrenal had been manufacturing with great difficulty.

In the Stein-Leventhal syndrome (bilateral polycystic ovary syndrome),²⁻⁴ we now know that these ovaries are producing androgen (testosterone) in excess. The normal ovary makes small amounts of androgen but the polycystic ovary exceeds this greatly. This abnormal synthesis (in amount, for the actual biosynthetic pathway may not be abnormal) probably follows the pathway that starts with a precursor of progesterone, pregnenolone, and then continues on to a substance known as dehydroepiandrosterone and finally testosterone. The enzyme, 3-beta-hydroxysteroid dehydrogenase is active in the conversion of pregnenolone to progesterone, and this may be a limiting factor in the Stein-Leventhal syndrome. For reasons which still are not clear enough to elucidate, wedge resection cures the problem. Other forms of therapy for this syndrome will be discussed in the next section.

There are some therapeutic compounds with reproduceable progestational activity now available that are not prohibitively expensive, and which are fully effective both orally and parenterally. Such compounds have been found and are derivatives of progesterone or derivatives of testosterone (via its less androgenic form—19-nortestosterone). Variations of 19-nortestosterone become potent progestins with minimal to no androgenic activity. All of these have great value in the therapy of menstrual disorders and, in fact, form the basis for the oral contraceptives that are so currently popular.

Finally, much has been learned about

estrogen metabolism. Estrone, estradiol, and estriol have been the major physiologic estrogens known, but we now know that there are many derivatives of these substances—e.g., isomeric forms, methyl derivatives etc. which are excreted in very small amounts. Some of these have achieved diagnostic significance and others probably will in the future as they become more readily measurable. Furthermore, estriol has recently reached new prominence as a measure of the integrity of a developing pregnancy.

However, advances have not been restricted to steroid chemistry. Great strides were made in genetics and these have diagnostic application.⁵ The normal total number of chromosomes in the human have been found to be 46 rather than 48. Chromosomal sexing and karyograms have come into their own. Abnormal numbers of sex chromosomes with unusual combination of X's and Y's have been found in patients with the Klinefelters' syndrome (puberal seminiferous tubule failure), gonadal dysgenesis, etc. Terms like non-disjunction, translocation, etc. of chromosomes have become more common terminology. Finally, further exciting developments have occurred. Substances which *indirectly* stimulate the ovaries as well as human pituitary gonadotropins which stimulate the ovaries *directly* have become available. These now provide us with a means of treating not only the anovulatory female, but also the female with deficient pituitary function. The human products have also been responsible for some multiple births. Thus, the recent past has been exciting in terms of developments in reproductive endocrinology, and now I should like to detail the applications of some of these advances.

Applications

1) *The Therapy of the Adrenogenital Syndrome.*⁶

The advantages of therapy in this syndrome, where medical therapy is indicated, are that it allows for (a) the development of a normal puberty in individuals who would not undergo such physiologic change without treatment, (b) it provides an other-

wise non-existent fertility potential (in the congenital form), (c) it may save lives in one life threatening form of the adrenogenital syndrome and, (d) it may convert hypertension to normotension in another form of this syndrome.

a) In the classic congenital adrenogenital syndrome, females are called female pseudohermaphrodites. They demonstrate clitoral enlargement and a persistent urogenital sinus. The males are called patients with macrogenitosomiapraecox. They have a precociously enlarged phallus but the testes remain small. Pubic and axillary hair are precocious in appearance and skeletal growth is advanced in both sexes. Pubescence does not occur in the untreated patient, and short adult stature is characteristic. The syndrome is characterized by elevated urinary levels of 17-ketosteroids, pregnanetriol and pregnanetriolone. These children have normal chromosomal sex patterns and their disease is usually secondary to adrenal hyperplasia. Corticosteroid therapy in physiologic doses—e.g., Prednisone—5 mgs. b.i.d. or t.i.d. will suppress the adrenal hyperplasia and allow for normal pubescence and fertility potential. If treatment is started early enough—normal growth potential may be achieved. At the time of this writing it is felt that therapy should be continued indefinitely. In the female, clitorectomy and surgical repair of the urogenital sinus must still be performed.

There is also an acquired prepubescent form of the adrenogenital syndrome which may be secondary to an adrenal tumor. In the female, there is no persistence of the urogenital sinus as genital differentiation is embryologically normal.

b) The acquired post-pubescent adrenogenital syndrome^{7, 8} may affect male and female but it is most difficult to recognize in the male. Normal pubescence has already occurred in these individuals and the adrenal hyperactivity may be mild to moderate in degree. In the female, masculinizing changes and alteration in menstrual function are superimposed upon normal genitalia and established menses. A loss of fertility potential occurs which may or may

not be associated with polycystic ovaries. The latter are more apt to occur only in the milder forms of apparent adrenal overactivity. The male has no obvious physical changes or problems except that as part of a fertility workup his semen may be noted to be deficient. In both instances, moderate elevations in urinary 17-ketosteroids may be found and therapy with corticosteroids in physiologic doses will often restore fertility potential.

c) There is one form of the congenital adrenogenital syndrome that becomes clinically apparent in fulminating fashion in the first week(s) of postnatal life. This is characterized by marked salt depletion, dehydration and death if unrecognized and untreated. Urinary 17-ketosteroids and pregnanetriol are elevated. Corticosteroids (e.g., cortisone, desoxycorticosterone, etc.) salt and water, etc. are specific in their effects and life-saving.

d) There is another form of the congenital adrenogenital syndrome that is associated with hypertension. Urinary 17-ketosteroids and pregnanetriol are elevated but these patients also have an increased excretion of a substance known as tetrahydro "S." An adult version of this 11-beta-hydroxylase deficiency has been described where the hypertension was associated with a feminizing adrenocortical carcinoma.⁹ In all instances, therapy with corticosteroids in physiologic doses will restore normotensive levels but reversion to hypertension will occur if the therapy is discontinued.

e) There is a further form of the adrenogenital syndrome that is seen less frequently than the ones just mentioned. It is the form that is associated with a deficient conversion of pregnenolone to progesterone because of an enzyme deficiency.

2) *The Stein-Leventhal Syndrome*^{2, 3}

Although this syndrome, which is also known as the bilateral polycystic ovary syndrome, has not changed greatly since its original description in 1935, it has become more complex in many ways. It is a syndrome in which the ovaries may be enlarged, may be normal in size, may occur in the presence of apparent adrenal hyper-

plasia, may respond to an ovulation inducing agent as Clomid, and their steroid metabolism has been found to be abnormal. Wedge resection of the ovaries is still the therapy of choice. However, a question exists as to the optimal time for surgery, and whether medical therapy might not be more desirable in the individual who is too young for a fertility problem but who might have problems associated with excess ovarian androgen production or anovulation. In the performance of a wedge resection, ovarian mass is being removed with removal of some of the source of abnormalities in the biosynthetic pathways. Whether this, alone, is sufficient to correct the specific abnormalities of the syndrome is unlikely, as this merely decreases the degree of the abnormality. On the other hand, it would appear that the properly diagnosed patient who is so treated has a "permanent cure," and so this relatively simple procedure must have more explicit effects. It may have something to do with the normal feedback mechanism that exists between ovarian estrogen and/or androgen and the anterior hypothalamus which may be the controlling factor for ovarian cyclicity and ovulation. By reducing abnormal products, this feedback mechanism may be restored to normal function and excessive androgenic products (testosterone) that may be contributing to hirsutism may be diminished. This is one reason for doing wedge resection in the young girl with progressive hirsutism who is not interested in fertility potential at the time of diagnosis. Furthermore, it is in the interest of the patient to restore normal menses, as many patients with the Stein-Leventhal syndrome have anovulatory cycles characterized by meno-metrorrhagia. This may be associated with endometrial hyperplasia with its premalignant implications although this association has never been absolutely verified.¹⁰

In the section on the adrenogenital syndrome, it was noted that some patients with mild adrenal hyperplasia may have polycystic ovaries of the same variety seen in the Stein-Leventhal syndrome.⁷ Indeed, some investigators feel the two syndromes

are either directly related or are merely gradations of the same disease. In any event, it is important to do screening urinary 17-ketosteroids and pregnanetriol (if available). If these steroid levels are elevated, a trial of Prednisone, 5 mgs. b.i.d. or t.i.d. for 12 weeks should be implemented. Where adrenal hyperplasia exists, ovulation and or regulation of menses should be induced within that time, obviating the need for wedge resection. Existing hirsutism does not regress, but its forward progress may be slowed or stopped. Where special hormone tests can not be obtained, or as a combined diagnostic-therapeutic test in all cases of suspected Stein-Leventhal syndrome where specific contraindications to the use of steroids do not exist, one may use Prednisone or its equivalent in physiologic dosage for the 12 week period. If there is no change in the menstrual pattern on this trial of therapy, then wedge resection would be indicated.

There are some physicians who would treat the patient with the Stein-Leventhal syndrome by the cyclic administration of progestins to induce regular menstrual cycles and hopefully to regulate the hypothalamic-pituitary-ovarian axis. This is particularly true for the young unmarried female. However, this does nothing for their hirsutism if this is a problem, and does nothing for their basic ovarian problem. The only thing that it accomplishes is the initiation of regular artificial cycles.

Finally, an experimental medication is now being used for the trial therapy of anovulation.¹¹ This agent is called Clomid and is related structurally to the synthetic estrogen, Tace. It induces ovulation presumably by stimulating endogenous pituitary production and release of gonadotropin and so would seem to require an intact pituitary. This compound seems to work particularly well in the patient with polycystic ovaries. It is not commercially available but when it is used experimentally, it is given in varying regimes, one of which is 50 mgs. b.i.d. from Day 10 through Day 14 of the menstrual cycle. It produces undesirable side effects if given in larger or

more prolonged dosage. When ovulation is induced it is normal ovulation and the patient can become pregnant quite normally.

3) *The Therapy of Menstrual Disorders*¹²⁻¹⁴

The newer synthetic progestins and their outgrowth, the oral contraceptive agents, have done much to simplify the therapy of menstrual disorders. Ample references are available giving details of therapy and side effects, etc.; however, I will briefly detail programs in the various menstrual disorders.

a) Amenorrhea: In the therapy of primary or secondary amenorrhea, one should determine first whether or not the patient is producing adequate endogenous estrogen. This may be determined by vaginal smear, or by administering a pure progestin Provera, 10 mgs. b.i.d. for 5 days, Norlutin, 10 mgs. q.d. for 5 days, 250 mgs. of Delalutin, i.m. or 100 mgs. of Depo-Provera i.m. If the patient does not have a withdrawal period, then she is probably deficient in estrogen. Under these circumstances, the patient must be primed with estrogen continuously (Stilbestrol, 1 mg., Conjugated estrogens, 2.5 mgs.). The pure progestins may then be given in cyclic fashion each month to induce regular periods or one may use any of the oral contraceptives the last 7 days of each month to induce cyclic menses. If the patient has adequate endogenous estrogen, then one may use any of the oral contraceptives, for twenty days the first cycle, and then from Day 5-25 of subsequent cycles. Where endogenous estrogen is deficient, it is likely that the patient will require chronic therapy. However, if the patient demonstrates adequate endogenous estrogen, therapy should be stopped about every 6 months to determine if she is ready to resume normal spontaneous menstrual cycles.

b) Hypermenorrhea: If the patient presents with an acute bleeding episode in the adult age group, dilatation and curettage is the first therapeutic step. If the bleeding is recurrent after D & C or occurs primarily in a pubescent girl, then one may treat the acute bleeding episode by giving 375 mgs. of Delalutin, or 150 mgs. of Depo-

Provera, or one may institute large doses of one of the oral progestins for about 7-10 days to stop the acute bleeding episode. Withdrawal bleeding will then occur (usually heavy), but of a more controlled nature than the bleeding for which the patient was treated. Subsequently, the patients may be treated with one of the oral contraceptive agents for 4-6 months, at which time they can be stopped to determine whether the hypermenorrhea problem has been corrected. The pubescent age group and possibly the menopausal age group are the ones who are most apt to show the best response.

c) Dysmenorrhea: In patients with functional dysmenorrhea, the oral contraceptive agents have been most helpful. Therapy is really quite simple and is geared to the inhibition of ovulation just as in contraception but to a different end. The patient merely takes one of the oral contraceptive agents that are available in a dosage of one tablet each night from the fifth to the twenty fifth day of her cycle. If her dysmenorrhea gets worse, and in spite of the fact that endometriosis was not found on initial screening, endometriosis must be strongly considered.

d) Endometrial Carcinoma:¹⁵ Delalutin and Depo-Provera have been utilized in large dosage the past few years in the therapy of endometrial carcinoma (in addition to the usual means of therapy). Delalutin has been given in doses of 1-3 gms. per day, and Depo-Provera in comparable equivalent dosage, with alleviation of bleeding, etc. It is not curative but has been most helpful symptomatically.

e) Endometriosis: If the patient with endometriosis is fortunate enough to become pregnant, her symptoms disappear for the duration of the pregnancy and for a variable time thereafter. The newer progestins are utilized in continuous dosage for 9-12 months to induce a pseudo-pregnancy and to achieve the same results. When infertility is associated with endometriosis, this therapy does not supplant surgery but becomes a useful adjunct to surgery. One may use the parenteral progestins as described

in other menstrual disorders, or the oral progestins, but these all must be given with estrogen, OR one may use the oral contraceptive agents. The important thing to remember is that treatment is continuous so that amenorrhea is induced for 9-12 months. Where it is used in association with surgery for infertility, one may only wish to give it for 1-2 months preceding surgery, and for 1-2 months following surgery.

f) Breast Problems: The therapy of chronic cystic mastitis has always been a great problem. However, there have been some reports of success with oral contraceptive agents given twenty days of each month, and some investigators have tried the experimental drug, Clomid, with some success. Breast discomfort associated with premenstrual tension may also be treated in similar fashion.

g) Abortion: The therapy of threatened and habitual abortion with estrogen and progestins is often empiric because the causes may be completely varied and often unknown. For this reason it is almost impossible to establish a reliable series for evaluation. However, if one does not delude himself and realizes the empirical nature of the therapy, one may try using parenteral or oral progestins with estrogen, or the oral contraceptives in regular and often increasing dosage. One should be on the lookout for the possibility of missed abortion on such therapy.

h) Cyclic Acne: Many pubescent girls and adult women have an exacerbation of acne just preceding and during their menstrual cycles. Females with this problem who had been on oral contraceptives, noted marked improvement of this cyclic acne as an unexpected finding. This now has been a frequent finding and such therapy may be specifically utilized for this purpose.

4) *Therapy for the Suppression of Lactation*^{16, 17}

Where breast feeding is not desired and where this is known prior to delivery, therapy is available to suppress lactation and prevent the symptoms that may be associated with painful engorgement. This is in the form of an estrogen-androgen combina-

tion, Deladumone, which is given intramuscularly immediately following the second stage of labor. This will suppress lactation and engorgement in the majority of cases. Where an oral preparation is preferred, the synthetic estrogen, Tace, has been fairly effective.

5) *Oral Contraception*^{18, 19}

This has been probably the most publicized and widely used of the recent advances in reproductive endocrinology, as well as one of the most satisfactory. There are at least six preparations available that are essentially 100% effective as contraceptive agents, providing they are taken as prescribed. This means, usually, that they are taken in a dose of one tablet a day for twenty days each month from the fifth to the twenty fifth day of the menstrual cycle. This provides freedom from fear of conception and at the same time regularizes menstrual cycles. One may also use an oral estrogen from the fifth to the twentieth day of the cycle, and then one of the oral contraceptives for the next five days. The estrogen would inhibit ovulation and the oral contraceptive would bring on a more normal period than would be induced by estrogen alone. The term, oral contraceptive pill, is being used to denote a class of medications that contain a synthetic progestin plus an added estrogen.

6) *Therapy for Anovulation*

There is only one group of medications that is commercially available for this purpose and it is not always successful. These are the oral contraceptives, which are given in the usual fashion for 3-6 months and then stopped, hoping for an ovulatory rebound. Clomid¹¹ and Human FSH^{20, 21} (obtained from human pituitaries or from menopausal urine) have also been used for the same purpose and with much greater and more reproducible success, but they are experimental only and are not commercially available.

7) *Therapy for Growth Problems*

a) Short Stature:²² Where the problem of short stature is not due to a bone disease or condition whereby additional growth

could not be obtained under any circumstances, then one has various medications that can be tried. The best of these, human growth hormone, is available only experimentally but it is capable of inducing the most growth. Hopefully, a synthetic form will be available in the future. Practically speaking, therefore, the only agents we have available are the anabolic agents plus thyroid. This combination may induce additional growth in the short statured individual. The only question is whether the growth increment that occurs is above that which would have taken place without such therapy over a period of time. It goes without saying that such treatment is only efficacious where epiphyseal growth is still possible. One must be aware of the potential side effects of masculinization, particularly in the female, with such therapy.

b) Potential excess height;^{23, 24} This is particularly applicable to the young girl with a family background for great height and where the family is concerned about this height. Therapy is available for treating this problem, but again we do not know whether the height eventually reached by a child so treated is what would have occurred without therapy or whether actual curtailment of predicted height has taken place. The reports in the literature are conflicting. There are some who advocate early therapy but I feel that therapy *much* before normal puberty, substitutes other psychological problems for the height. Therapy involves the administration of estrogen either orally or parenterally to hasten bone maturation and thus attempt to induce premature epiphyseal closure. One must add a progestin to this regime in cyclic fashion to prevent abnormal menstrual bleeding.

8) *Therapy for Chromosomal Disorders*^{5, 6}

This applies to such conditions as Turner's syndrome, gonadal dysgenesis, or the Klinefelter's syndrome. In the female where secondary sex characteristics have not made their appearance, estrogens are used in continuous fashion to induce such changes. Then they are treated in the same manner hormonally as the patient with primary amenorrhea. In the patient

with the Klinefelter's syndrome, substitution testosterone therapy, either by buccal linguets or by parenteral medication, is given in regular and chronic fashion where the need for same is demonstrated because of specific deficiencies.

There have been remarkable advances made in the past few years in the immunology of infertility,²⁵ although this is not directly a hormonal problem. The development of antibodies by the wife to the husband's sperm or semen, problems of ABO incompatibility etc. have all been found as potential causes for long standing infertility. Much work remains to be done to document these findings which are still somewhat controversial, as well as to find means of correcting or overcoming them. One rather simple form of therapy that has been used, is the use of the condom by the affected couple for up to 6 months to separate the semen from the vaginal secretions. This is done with the hope that removal of the constant antigen-antibody stimulus will allow for a fall in the antibody titer in the wife.

This has been a limited review rather than an exhaustive treatise and therefore elaborate details have been eliminated but adequate references have been provided so that additional details may be obtained. It is also conceivable that certain advances have been left out, but only because it was felt that they are not as important as the ones included. In any event the advances in reproductive endocrinology over a relatively short span of years, have been nothing short of remarkable and we are proud of all of them.

Summary

A short review of recent advances in reproductive endocrinology has been presented. The increase in our knowledge of steroid chemistry has sparked many of these advances and has also increased our knowledge of many prior endocrinologic enigmas. We have learned much about the adrenogenital syndrome and expanded the concepts of the Stein-Leventhal syndrome. We have been able to treat many menstrual disorders more intelligently, more success-

fully and more cheaply than in the past. Oral contraceptive agents have found their place in the world as a means of controlling a rapidly expanding birth rate, as well as being useful in regularizing menstrual cycles, treating cyclic acne etc. Newer therapies are also in the process of trial for the successful induction of ovulation in the anovulatory infertile female. The significance of these advances as well as the rapidity of progress has carved out a niche for the growing field of reproductive endocrinology.

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A STATEMENT OF BELIEF

It does not take an expert to classify the active leaders of a community as usually being sane, and the delusional, hallucinating patients in a locked ward as being mentally ill. However, as we approach a midway point along the continuum between these two extremes we reach a point of confusion. People can be sane at one time and psychotic at another; one can be a little bit crazy; the sanest person has moments when he is mentally unbalanced and the most chronic psychotic patient goes through periods of lucidity. Mental illness is not like pregnancy (whoever heard of a woman being a little bit pregnant?) and as yet we have no pathognomonic signs, symptoms or tests to establish its presence or absence. Just imagine what a psychiatric equivalent of Koch's postulates would mean today. As an example, after a serological test for syphilis was discovered the number of patients diagnosed as paretics was reduced 50%. *Virginia Medical Monthly*, Volume 91, November, 1964.

EDITORIALS

ROUTINE BLOOD GLUCOSE DETERMINATIONS TO DETECT TRANSIENT SYMPTOMATIC NEONATAL HYPOGLYCEMIA

The diagnosis of transient symptomatic neonatal hypoglycemia has been stressed by Doctor Marvin Cornblath, of the Department of Pediatrics of the University of Illinois, in a paper appearing in the *New England Journal of Medicine* August 12, 1965.¹

Doctor Cornblath found transient symptomatic neonatal hypoglycemia in 4 to 6% of a large series of premature infants. Hypoglycemia is defined as a blood glucose level below 20 mgm. per 100 ml. in the premature infant and below 30 mgm. per 100 ml. in the full sized newborns in the first forty-eight hours. He noted that these infants were smaller than their gestational weight would indicate. Most of the patients were males and the smaller of those cases occurring in twins.²

Doctor Cornblath also advises that blood glucose determinations be done immediately, since increased glycolysis occurs in the bloods of newborns if they are left at room temperature for any length of time.³ He advocates the glucose oxidase method for determining true blood glucose of the newborn.⁴

There has been a great emphasis on screening procedures for the detection of

PKU and the many other specific amino-acidurias. It would seem worth while for all hospitals to consider the institution of routine blood glucose determinations in their newborn nurseries. The chances of finding transient symptomatic neonatal hypoglycemia can be calculated to be 500 to 1000 times greater than uncovering one case of PKU.

Another cogent reason that blood glucose should be determined in the newborn is to prevent mental retardation. It has been estimated that 20% of the cases treated for transient symptomatic neonatal hypoglycemia showed subsequent mental retardation. Only by carefully carried out routine blood glucose determinations can these cases be uncovered before irreversible brain damage results.

Harvey Kravitz, M.D.

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LEGISLATION FOR BLOOD ALCOHOL AND CARBON MONOXIDE STUDY PASSED

Governor Kerner recently signed H.B. 1362 which amended the Coroner's Act. The Amendment requires that a blood specimen of at least 10 cc. be withdrawn from the body of the driver or occupants within 24 hours after death resulting from vehicular accidents.

Blood specimens shall also be taken from

pedestrians killed by motor vehicles. (To all intents and purposes, only blood specimens from pedestrians 16 years of age or older would be submitted for study.)

The purpose of this study, sponsored by the Illinois State Medical Society and the Illinois Department of Public Health, in cooperation with the Illinois Coroners As-

sociation, is to obtain reliable statistics on the role alcohol plays as contributing factor to motor vehicle deaths. An additional finding will also reveal the role, if any, of carbon monoxide asphyxiation in these deaths. The same sample of blood submitted as above will also be tested for carbon monoxide content. It is anticipated that approximately 2,000 blood specimens will be examined during the year of the study, January 1, 1966 to December 31, 1966.

The specimens will be collected and shipped to the designated laboratories in containers supplied by the Division of Laboratories of the Illinois Department of Public Health.

The Laboratory of the Cook County Morgue, located at 1828 West Polk Street, Chicago, will do the analysis on those bloods submitted from all Cook County Hospitals, including those of the City of Chicago. Blood specimens from all other counties in the state will be sent to the Division of Laboratories, 1800 West Fillmore Street, Chicago.

It is anticipated that all coroners in the state will issue standing orders to all hospitals in their jurisdiction to draw blood specimens from deceased drivers, occupants or pedestrians as outlined in the foregoing and send them to the Laboratory of the Cook County Morgue, or to the State Health Department Laboratory.

The bill also provides for the coroner to receive a fee of \$5.00 for each blood specimen sent to the State Health Department Laboratory.

All reports of analyses for alcohol and carbon monoxide will be sent to the Division of Preventive Medicine, Illinois Department of Public Health, at Springfield, Illinois. The coroner causing blood to be withdrawn shall be notified of the results of analyses made by the State Department of Public Health. All results will be confidential and cannot be used in a court of law, and any person drawing blood and any person making any examination of the blood under the terms of this Act shall be immune from all liability, civil or criminal. (Section 10 (e) this Act.)

It is earnestly requested that all physicians who are asked by their coroners to cooperate in this study lend their support to this important public health measure. Valid and convincing statistics will be gathered for the first time on a state-wide basis for one year and should dispel conflicting or unfounded opinions concerning the role of alcohol and carbon monoxide in vehicular fatalities.

Julius M. Kowalski, M.D., Chairman
Committee on Public Safety
Norman J. Rose, M.D., Chief
Bureau of Epidemiology

PROGNOSIS OF STROKE SURVIVORS

Doctor G. F. Adams¹ began his F. E. Williams Lecture to the Royal College of Physicians of London with an excerpt from King Solomon's portrait of old age: "A disease of old age (stroke), which might surprise a man, and yet not immediately kill him, and of which there might possibly be a removal, at least for a season, that there might some space be given him to recover a little strength, before he go home and be no more seen."

Dr. Adams stressed the importance of rehabilitation in the treatment of those who survive hemiplegia. He compared the results of treatment of 736 of these patients

during 1948 to 1956 with 777 similar patients treated during 1959 to 1963. Half of the first group and two-thirds of the second group recovered to the extent of being able to walk and look after themselves. One quarter of the second and one-half of the first group became chronic invalids.

The second group had the advantage of being in an institution with a specially designed rehabilitation wing. Factors influencing the prognosis in both groups were the extent of intellectual damage, the time elapses between the stroke and the first attempt to restore activity, and the coopera-

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Side effects: the incidence of drowsiness and other atropine-like effects is low. However, caution patients engaged in activities where alertness is mandatory.



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tion of the patient and his family.

In his review of the literature Dr. Adams makes several references to those old timers who distinguished apoplexy from residual paralysis or who distinguished "apoplexies degenerating into palsy and those progressing to coma and death." This is important when considering rehabilitation. Caelius Aurelianus introduced a system of treatment in the fifth century that might be considered modern today. "He recommended passive and active movement; heat, as warm wax or bathing in hot springs; appliances such as weights, pulleys and a

special walking chair; swimming with inflated bladders to support paralysed limbs; and he particularly required the patient to join in the effort himself and not to rely on others for his exercises."

Adams also warned against lowering blood pressure after strokes especially in elderly patients. A good head of pressure is needed to maintain cerebral circulation. In addition these atherosclerotic vessels are less vulnerable to bleeding than to clotting.

T. R. Van Dellen, M.D.

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MAJORITY RULE DESTRUCTIVE TO MEDICAL FREEDOM

There are few people, doctors included, who have not been taken in by the liberal cliché, "The people want it," or, "you believe in the majority rule and the democratic process, don't you?" Let us have a good hard look at this high and mighty rule which, under certain conditions has its merits but which under other conditions should not and must not be used.

History has established Benjamin Franklin as a master of political philosophy and science. Thomas Jefferson has been given credit for his mastery of the written word in the expression of political beliefs that formulated the Constitution and established certain God-given rights of the American citizen that superseded all other powers of the government. The most significantly important function of government was to protect these rights of individuals against the forceful rule of a majority. Indeed, these rights were not to be violated, abused or altered under any circumstances. To do so, using the ruse of majority rule, would destroy the essence of liberty and the unalienable rights of free men. A constitutional republic subjected to the use of majority rule was most feared by those lovers of freedom when they gave Americans a constitutional republic and not a democracy. They knew well that freedom of the individual would be lost if the rights of the minority were subjected to the will of

the majority and that a democratic despotism could arise and with its power to rule by force of law erode human freedom.

Today we are witnessing an erosion of human liberty and freedom using majority rule and extended voting rights as a political weapon. Legal justice and due process of the law are being displaced by a new kind of law called social justice that distorts equity and destroys the right of property.

Where do we doctors fit in this arena of human action and turmoil? Certainly, as citizens we still have certain rights, or do we? Have we not the right to think and act as free men? Do not our services constitute our property? Are not rights to property rights of individuals? In these troublesome days when human activity is being subjected to agitative pressures of government that would change our constitutional republic to a democracy, destroy the greatness of rugged individualism, replace a government of laws with a ruling body of men, and eventually harness the creative and productive talents of our people, let us not despair and seek actions that will deny doctors of medicine their freedom to dispense their services at their own discretion and their own price.

It would be well to emphasize to men of medicine the close relationship between medical and political freedom.

M. R. Saxon, M.D.

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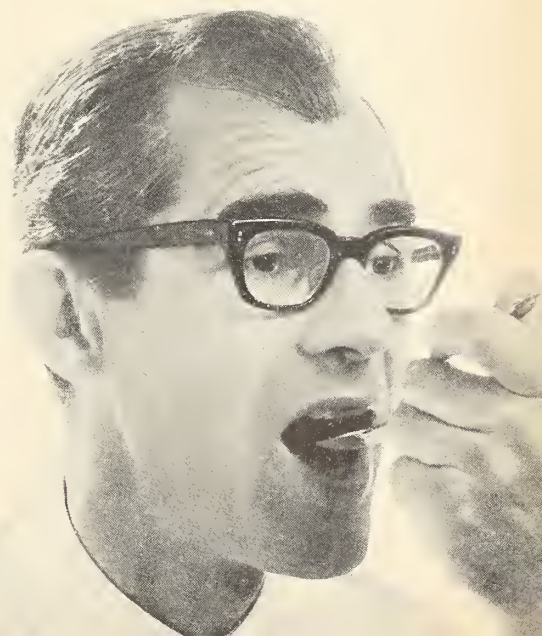
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EXPERIENCE IN RENAL TRANSPLANTATION. Thomas E. Starzl, M.D., Ph.D. W. B. Saunders Company, Philadelphia, 1965.

This book presents a detailed study of all 75 cases of human renal transplantation performed at the University of Colorado Medical Center from March 1962 to March 1964. Rather than compare or contrast his experience with that of others, Dr. Starzl outlines the problems encountered and the solutions developed by one institution in establishing a practical method of clinical transplantations.

Beginning with an analysis of donors and recipients, the author discusses each of the pertinent factors which have resulted in a strict list of indications and contraindications used in patient selection. He explains in detail the surgical techniques used in both donor and recipient operations. The chapters on immunosuppressive therapy, graft injection and its reversal, and host graft adaptation describe the evolution of currently acceptable techniques used in dealing with these problems.

The results of this large series are carefully analyzed. Many of the complications such as drug toxicity, late rejection and the unusually high incidence of infectious disease contributing to 27 of the 33 deaths are unique to this field. These problems are discussed with detailed grafts illustrating the patient's course and the effects of subsequent therapy. In addition, each example is cross referenced to an appendix which summarizes all 75 case histories bringing them to date as of June 1, 1964. These discussions of graft failure, complications and mortality perhaps constitute the most valuable contribution of this excellent book.

Included in this series are six patients who received heterotransplants of baboon kidneys. All these cases resulted in failure, the longest kidney surviving 60 days. These patients are discussed separately and are contrasted to the results obtained by Reemtsma using chimpanzee renal heterografts.

Finally the gross and microscopic findings in all rejected or autopsied specimens are studied. Current concepts of the pathophysiology of graft rejection are described and illustrated with excellent photomicrographs showing graft infil-

tration by host mononuclear cells, disruption of peritubular capillaries and venules, and vascular fibrinoid necrosis.

As with any textbook study of an experimental field some of the concepts eluded to in this book have already been altered; no doubt, many more will eventually change. The book provides the reader with an understanding of the problems of organ transplantation, is an invaluable guide to the current methods of therapy and gives insight into the future of renal transplantation.

Stuart M. Poticha, M.D.

A SYNOPSIS OF CARDIOLOGY by W. I. Gefter, B. H. Pastor, and R. M. Myerson. C. V. Mosby Co., St. Louis, 1965. 877 pages, 240 illustrations. Price \$9.85.

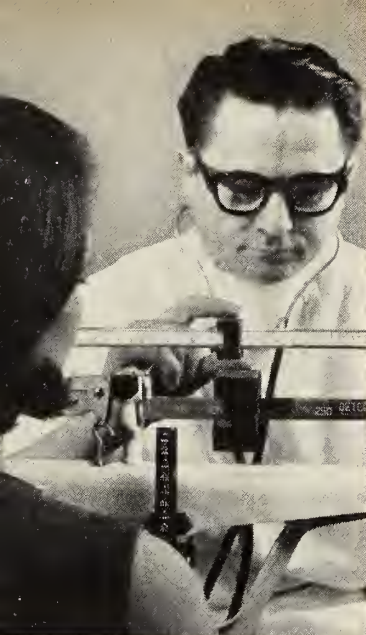
This sounds like a small tidy volume but in fact it is a generous sized compendium of information extending beyond its title of "cardiology" into a discussion on shock, syncope, and vascular disease to mention a few of the topics. In format, it is small in page size; in length, it includes 43 chapters and nearly 900 pages so do not expect to read it through in an evening.

I found it to be on the whole a good job, quite complete and generally sound in its tone. It should be useful to students for a fairly succinct presentation of most of the areas they might wish to review in essentials. I would not believe the volume to have much attraction for internists and subspecialists, and it should not be employed as a reference source due to its relative brevity and its modest bibliography at the end of each chapter.

Parts of it are first class. I was impressed by the aim of the authors to try to discuss hemodynamic principles and mechanisms, and was gratified by generally excellent illustrations. The chapter on electrocardiography and vectorcardiography is very good as is the chapter on roentgenology. The section on other graphic methods is on the whole very well done.

The first chapter (on the history and physical

... continued on page 454



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Book Reviews

... continued from page 452

examination) was less than adequate; for example, the authors seem to have no interest or knowledge regarding the proper use of the stethoscope. The section on cardiac insufficiency would not be very useful to students in my opinion as the various factors involved in states of circulatory congestion and myocardial failure are poorly differentiated. Elsewhere, the possible disadvantages of prophylactic digitalization are not considered, there is an unwarranted emphasis on pericardial effusions secondary to congestive heart failure, and the upper limit of the intravenous dose of procaine amide used in ventricular tachycardia is often more than 1.0 gm. There should be an explicit statement that sulfonamides should not be used in the treatment of beta hemolytic streptococcal infections instead of the vague sentence employed, and the management of the patient with myocardial infarction has to my thinking several objections (too late use of commode, excessive reliance on the ECG as a guide to the patient's course, uncritical initial use of heparin, etc.).

However, in a volume of this size, such occasional defects are surprising and doubtless will be corrected in later editions. The authors, including the late Dr. Pastor, are to be commended for their efforts.

Oglesby Paul, M.D.

TRAUMA TO THE LIVER. G. F. Madding and P. A. Kennedy. W. B. Saunders Company, Philadelphia, 1965.

This monograph constitutes Volume III in a group of publications entitled "Major Problems in Clinical Surgery."

As with the two earlier volumes, this book maintains a high standard. The authors have discussed liver injury in a concise manner and have presented the basic principles that should be followed in the management of trauma to the liver.

Chapter I deals with the surgical anatomy of the liver and forms a sound basis for the discussion of the clinical problems in the succeeding chapters. The illustrations are of good quality and clearly demonstrate the clinical and anatomical problems encountered in damage to the liver.

The monograph includes adequate discussion of diagnostic methods, including abdominal tap, and problems in treatment, including hypothermia. The need for appropriate and adequate drainage receives the proper emphasis.

A carefully chosen bibliography accompanies each chapter.

This book should be a welcome source of reference for surgeons who treat abdominal injuries and should be valuable for surgical residents.

John M. Beal, M.D.

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No specific contraindications are known. Since large doses can produce peripheral vasodilation, the drug should be used cautiously in patients with hypotension and in acute myocardial infarction when the blood pressure may be labile. Headache, dizziness, nausea, flushing, weakness or syncope, and mild gastrointestinal distress have been reported.

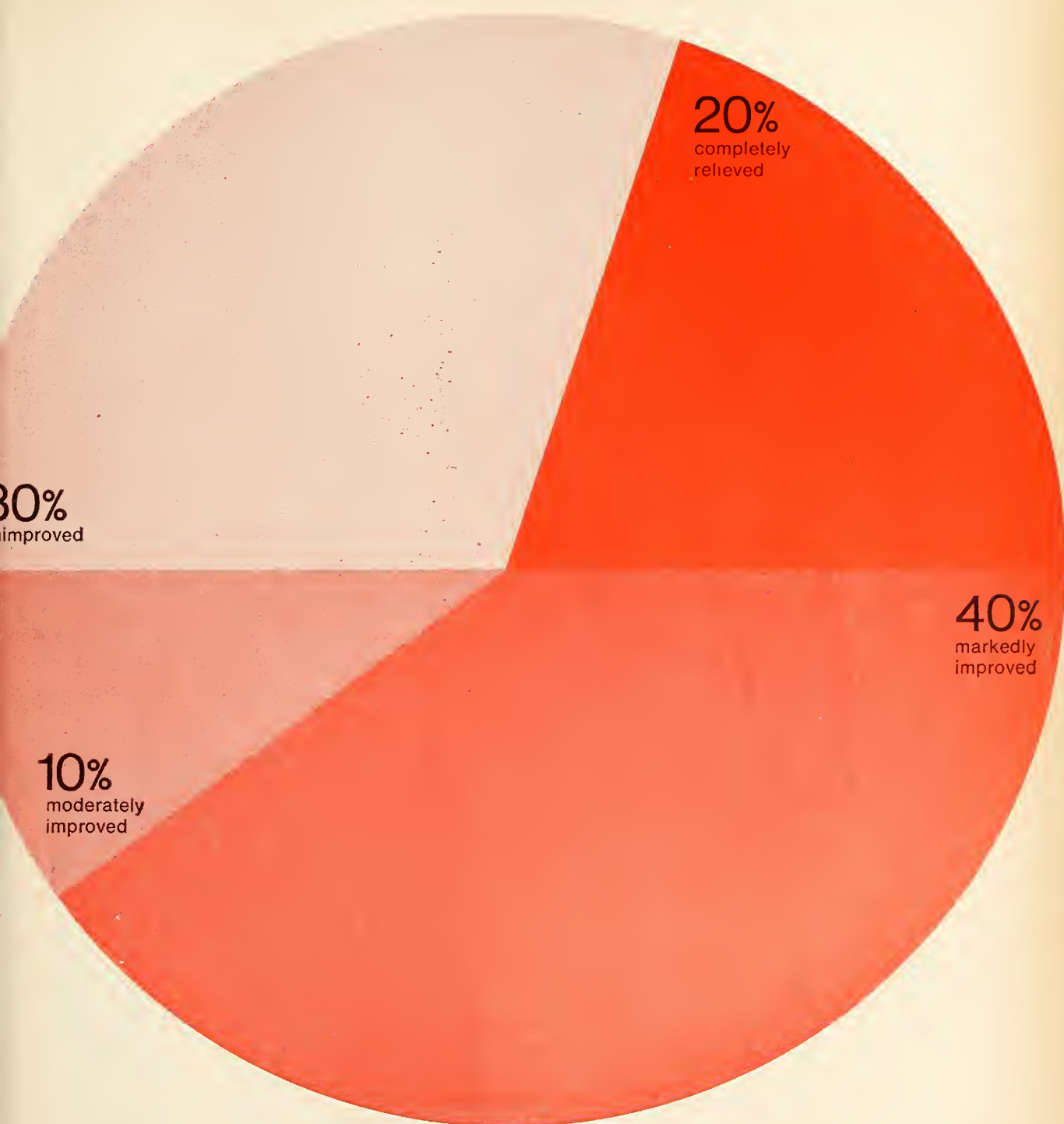
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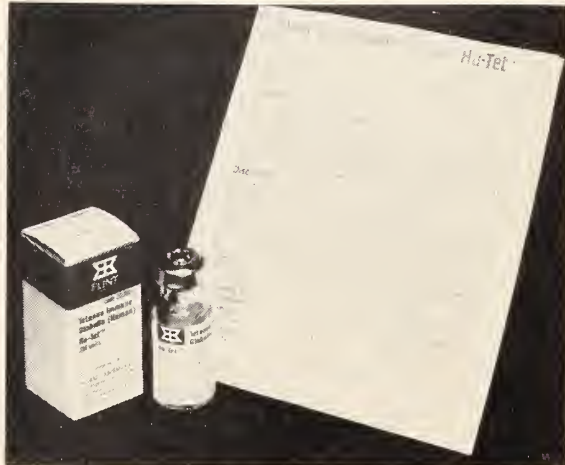
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Rx Reviews

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HU-TET is administered intramuscularly; the routine prophylactic dose for adults is 250 units. A proportionately smaller routine dose based on body weight, is recommended for children.

Larger Size Lif-O-Gen

Lif-O-Gen, Inc., manufacturers of the first portable, disposable emergency oxygen unit, has announced development of a new larger size dispenser containing two and one-half times the volume of pure oxygen as its original No. 210 model.

Designated the Lif-O-Gen No. 200 Unit, the respirator provides a continuous 25-minute flow of oxygen from its 58-liter tank.

Although similar in appearance to the well-known but smaller 22-liter 210 Unit, this latest addition incorporates two important new features for convenience and durability. A lever-type operating valve is used on the 300 Unit in place of the 210's push button valve, and the tank is made of steel instead of aluminum. The new unit is compact and easily carried, yet provides a sufficient quantity of oxygen in an emergency situation. It is four inches in diameter, 12 inches long, weighs less than three pounds, and holds approximately 15½ gallons of oxygen under pressure.

As with the Lif-O-Gen 210 Unit, a face mask and connecting tube are included with each 300 Unit to provide inhalation of the highest possible concentration of oxygen. The cylinder can also be used without the mask simply by placing the valve tip in the patient's mouth and pushing the operating lever each time he inhales.

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... continued on page 459



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Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

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R Reviews and New Products

... continued from page 456

smaller 210 Unit are available from medical and hospital supply houses as well as from normal drug sources.

For further information on Lif-O-Gen portable, disposable emergency oxygen units, write to Lif-O-Gen, Inc., P.O. Box 302, Lumberton, N. J. 08048.

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1. Conant, R. G.: Reduction of industrial time-loss: treatment with carisoprodol compound in musculoskeletal disorders. *Industr. Med. Surg.* 33:25, Jan. 1964.

Also available with ¼ gr. codeine as 'Soma' Compound with Codeine: carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

Indications: 'Soma' Compound and 'Soma' Compound with Codeine are useful for relief of pain and stiffness in traumatic, rheumatic and other conditions affecting muscles and joints. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol, phenacetin, or codeine phosphate. **Precautions:** *Phenacetin*—With long term use, give cautiously to patients with anemia and cardiac, pulmonary, renal or hepatic disease. May damage the kidneys when used in large amounts or for long periods. *Caffeine*—Not recommended for persons extremely sensitive to its CNS stimulating action. *Codeine phosphate*—Use with caution in addiction-prone individuals. *Carisoprodol*—Carisoprodol, like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g. meprobamate. **Side effects:** Drowsiness, lightheadedness, dizziness, and gastric complaints have been reported infrequently for either or both of these preparations. *Phenacetin*—Side effects are extremely rare with short term use of recommended doses. Prolonged ingestion of overdoses may produce dyspnea, cyanosis, hemolytic anemia, skin rash, anorexia, subnormal temperature, insomnia, headache, mental disturbances, and tolerance. *Caffeine*—Side effects are almost always the result of overdosage. Average doses may rarely cause nausea, nervousness, insomnia, and diuresis. Excessive dosage may produce, in addition, restlessness, nervousness, tolerance, tinnitus, tremors, scintillating scotomata, tachycardia, and cardiac arrhythmias. *Codeine phosphate*—Possible side effects are nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms. One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reaction, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression. **Dosages:** Usual adult dosage of 'Soma' Compound or 'Soma' Compound with Codeine is one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white capsule shaped tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*



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What is the single most important contribution to drug research?

It was made 175 years ago

when President Washington signed the first U.S. patent law. For patents mean drug progress. For example, of the 604 important drugs introduced worldwide since 1941, the majority originated in the U.S. drug industry. By contrast, a major west European nation, which has no patent protection, contributed one. How great is the contribution of drug patents? The answer is told in life itself: our children live 10 years longer than we, and need not suffer polio, measles, diphtheria, tuberculosis, rheumatic heart disease, and a dozen other illnesses we grew up fearing. We can expect these benefits to multiply—as long as our patent system remains strong.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W. Washington, D.C. 20005



**ILLINOIS
MEDICAL
ASSISTANTS
ASSOCIATION
REPORT**



HOW YOU CAN HELP US, DOCTOR

Do you wonder, doctor, why you should encourage your medical assistant to join the Illinois Medical Assistants Association? Do you wonder if you should give it your personal support—either in time or as a booster? In other words, do you wonder what YOU will get out of it?

The answer is that you should encourage your assistant to join, because IMAA concentrates on the education of its members so that the medical assistant can aid her doctor-employer in improving medical public relations. It features programs which are a help to all its members, regardless of their training. The local societies have frequent presentations on medical law—some by doctors, others by lawyers—so that the medical assistant has a thorough understanding of this area of a doctor's practice.

For the medical assistant whose background is office practice and management, programs on medical subjects are presented to give her a better understanding of her job. Cancer, office ophthalmology, diabetes, the importance and proper techniques of x-ray and the physical examination are typical topics covered. She also learns better and faster ways of doing her own work.

For the medical assistant who is a nurse, medical technologist, or x-ray technician, subjects of a business nature are included so that she may be able to work efficiently in an area for which she may have little or no previous training, such as credits and collections, banking procedures, checking accounts and billing procedures. That our organization definitely has something to offer nurses is borne out by the large num-

ber of registered nurses who are members and who renew their membership every year. Many of the national, state, and local officers are nurses. Medical technologists and x-ray technicians in small offices often have to act as relief or back-up receptionist, so they too, are helped by these programs.

Since forty percent of all doctors' offices are still one-girl offices, it is essential that the medical assistant, whatever her previous training, have a thorough understanding of all aspects of medical assisting. A lack of this could cost YOU, doctor, patients—money—and time.

Such a well-rounded assistant, by bringing a better understanding of her job to the office will use finesse, patience, tact, and discretion in her relationships with the patients.

YOU, doctor, should give these programs your active support, because it is through doctors like yourself that IMAA members learn. It is through IMAA that the medical assistant can voluntarily improve herself. In areas of low population density, where the general practitioner is the rule rather than the exception, the members plan programs that help them with their particular problems, with the local doctors supervising their study. In metropolitan areas where specialties are the rule, the members plan programs that help them understand fields of medicine other than that of their doctor-employer, as well as programs that help them understand their own job better. Here again it is the local doctors that work with the county society. With this additional knowledge your assistant is much more valuable to you in your office.

Special cough formula for children

Pediacof[®]

Each teaspoon (5 ml.) contains codeine phosphate 5 mg.,
Neo-Synephrine[®] hydrochloride (brand of phenylephrine hydrochloride) 2.5 mg.,
chlorpheniramine maleate 0.75 mg. and potassium iodide 75 mg.

soothing decongestant and expectorant



**bright red,
pleasant-tasting,
raspberry-flavored syrup**

Pediacof is different. It is designed especially for children, and each ingredient is in the right proportion. The potassium iodide in Pediacof is so well masked that it is virtually unnoticeable. Children like the sweet raspberry flavor of bright red Pediacof.

Dosage: Children from 6 months to 1 year, $\frac{1}{4}$ teaspoon; from 1 to 3 years, $\frac{1}{2}$ to 1 teaspoon; from 3 to 6 years, 1 to 2 teaspoons; and from 6 to 12 years, 2 teaspoons. These doses are to be given every four to six hours as needed.

How supplied: Bottles of 16 fl. oz.

Available on prescription only.
Exempt Narcotic.

relieves **cough**
nasal drip
congestion
running nose
sneezing

eases **expectoration**

Side effects: The only significant untoward effects that have occurred are mild anorexia and an occasional tendency to constipation. However, discontinuance of Pediacof has seldom been required. Mild drowsiness occurs in some patients but, when cough is relieved, the quieting effect of Pediacof is considered beneficial in many instances.

Precautions and contraindications: Patients with tuberculosis or those who are known to be sensitive to iodides should not be given Pediacof.

Caution should be exercised if Pediacof is administered to patients with cardiac disorders, hypertension or hyperthyroidism.

Warning: May be habit forming.

Winthrop Laboratories
New York, N.Y.

Winthrop



ILLINOIS ASSOCIATION OF THE PROFESSIONS

Illinois Association of the Professions Elects New Officers

Amos M. Pinkerton, LL.D., of the Illinois State Bar Association has been elected president for 1965-66 by the Illinois Association of the Professions. New vice-presidents for the upcoming term are: C. Dale Greffe, Illinois Society for Professional Engineers; Fred Bazola, D.D.S., Illinois State Dental Society; Edward J. Walchli, Illinois Council, American Institute of Architects; Edward A. Piszczek, M.D., Illinois State Medical Society; and Glen I. Case, D.V.M., Illinois State Veterinary Medical Association. Richard S. Strommen, R.Ph., of the Illinois Pharmaceutical Association, has been named secretary-treasurer and Robert L. Richards, Executive Administrator of the Illinois State Medical Society, is the Executive Director.

IAP Plans Second Annual Meeting

The Illinois Association of the Professions has announced the preliminary program of its second annual meeting, scheduled for Sunday, November 21, 1965 at the LaSalle Hotel, Chicago.

The program will be as follows:

9:30 a.m.—Registration

10:00 a.m.—First General Assembly

COOPERATION AMONG THE PROFESSIONS

"Effect of the 1965 General Assembly on the Professions — What to Expect in 1967"

Panel Discussion

"Collective Bargaining for Technical and

Professional Employees"

"National Labor Relations Board Rulings Affecting the Professions"

"Individual and Group IAP Membership Benefits"

Special Committee Reports (Policy, Membership, Nominating, Finance, Resolutions)

Noon—Cocktails

12:30 p.m.—Lunch

"Federal Support for Professional Schools," U. S. Congressman Robert C. McClory

Deans of the Illinois Professional Schools are Special Guests

2:00 p.m.—Second General Assembly

"Professional Career Education Programs"

"Who are We?"

"The Department of Registration & Education in Illinois," John Watson, Director, Illinois Department of Registration and Education

"Our Most Difficult Problem with the Department"

Panel Discussion

4:00 p.m.—Annual Business Session

6:00 p.m.—Reception

7:00 p.m.—Dinner-dance

Speaker: William G. Clark, Attorney-General of the State of Illinois

All members of the Illinois Association of the Professions and their guests are invited to attend.

... continued on page 466

to help relieve pain
in common
anorectal disorders

“non-caine” Diothane®

Diothane—with its chemically distinct “non-caine” anesthetic agent dipiperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

DIOTHANE OINTMENT

COMPOSITION:

dipiperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:

Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.



DIOTHANE SUPPOSITORIES

COMPOSITION:

Each suppository, weighing approximately 2.6 Gm., contains dipiperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:

Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

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Cincinnati, Ohio 45215/Weston, Ontario

Illinois Association of the Professions

... continued from page 464

Deerfield Principal Honored



The Illinois Association of the Professions honored Oscar Bedrosian, center, principal of Wilmot Junior High School, Deerfield, Illinois, with a certificate of appreciation for distinguished service to IAP and outstanding contributions rendered on behalf of the professions. The award, made at a recent IAP meeting, was presented by President Amos Pinkerton, left, and Edward J. Walchli, chairman of IAP's Educational Committee.

Mr. Bedrosian was honored for his efforts in educating Wilmot students in the professions of medicine, law, engineering, dentistry, architecture, pharmacy and veterinary medicine.

Hospital Utilization Committees To Be Discussed At AMA Conference

"Medical Staff in Action—1965, The Utilization Committee," will be the theme of the seventh annual Conference on Medical Services to be held Saturday, November 27, 1965 in Philadelphia, the American Medical Association has announced.

Sponsored by the AMA's Council on Medical Service and its Committee on Medical Facilities, the one day meeting will be held in the Bellevue Stratford Hotel preceding the AMA Clinical Convention.

The meeting will bring together recognized authorities from medicine, hospital administration, and other health agencies in order to explore the purpose, philosophy, modes of operation and value of medical staff utilization committees.

Conference participants will relate the utilization committee to the hospital, the medical staff and the medical society; examine the pros and cons of various review programs; and discuss the value of measurement tools and information systems in facilitating committee functions.

These experts will review the success of present programs in achieving established goals; and will look at the developing needs for, and new demands on, utilization committees.

For additional information write to the Department of Hospitals and Medical Facilities, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

IAP MEMBERSHIP APPLICATION FORM

PLEASE PRINT

NAME

ADDRESS

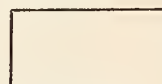
TOWN

SIGNATURE

DATE

I certify that this applicant for IAP membership is a member in good standing of our state professional association.

Please return this application form to the executive office of **your professional society**, along with your check for \$10 payable to the ILLINOIS ASSOCIATION OF THE PROFESSIONS.



Ex. Dir. initials



Dr. SIMS in ACTION

ADMINISTRATIVE AND COMMITTEE ACTIVITIES
OF THE ILLINOIS STATE MEDICAL SOCIETY

October, 1965

Committee on Scientific Assembly

The Committee on Scientific Assembly of the Illinois State Medical Society met on September 15, 1965, under the chairmanship of Dr. Robert T. Fox, to determine the schedule of the 1966 Convention.

The overall theme will be "Early Diagnosis" and the following Scientific Schedule was approved:

Monday, May 16: 9:00 a.m. "Occupational Health"; 1:30 p.m. "Section on Surgery" and "Section on Neurology and Psychiatry."

Tuesday, May 17: 8:30 a.m. "Section on Internal Medicine" and "Section on Obstetrics and Gynecology"; 9:00 a.m. "Section on Allergy"; and 1:30 p.m. "Section on Public Health," "Section on Radiology" and "Section on Physical Medicine."

Wednesday, May 18: 8:30 a.m. "Section on EENT," "Section on Pathology," "Section on Dermatology" and "Section on Pediatrics"; and 2:00 p.m. "Camp Lecture."

Medical-Legal Committee Meets with Illinois Bar Association

Medical-legal interprofessional liaison is effected through the Medical-Legal Committee of the Illinois State Medical Society and the Medical-Legal Cooperation Committee of the Illinois State Bar Association.

These committees met on September 10, 1965, to continue their discussions of topics pertinent to the interaction of medicine and law.

One of the topics considered was that of the "Interprofessional Code for Physicians and Lawyers of Illinois." (The code appears in the August 1965 *Illinois Medical Journal*, pages 250-253.) This document, prepared in 1960 and subsequently approved by the governing boards of both the ISMS and ISBA, was considered by members of both professions to be somewhat outdated in the light of present practices. Members of the ISMS committee suggested changes to the sections on the examining physician and medical expert in reference to the payment of fees for medical services rendered. The members of the Bar committee will analyze these changes and relate them to the statutes and the canons of legal ethics. This subject will be continued at subsequent meetings.

Another topic explored by committees was that of professional liability screening plans. The discussion at the recent meeting focused on medical malpractice screening plans recently adopted by the Philadelphia County Medical Society, the Philadelphia Bar Association and one proposed by the New Jersey State Medical Society for adoption by the New Jersey Supreme Court.

The committees realize that this subject requires intensive study by both professions. Consequently, the subject at the moment is academic and not action. The committees will continue to study and analyze the professional liability plans that are in operation in other areas.

The two committees will meet again in

November to continue their deliberations of the topics mentioned.

Chairman of the Medical-Legal Committee is Dr. Luis V. Amador; staff members are: Drs. Clinton L. Compere, W. W. Dalitsh, John G. Meyer and George C. Turner. Members of the Illinois Bar Association Committee are Louis G. Davidson, chairman; Carl Miller, Philip Corboy, Lloyd Van Deusen, Harlan Hackbert and John Moelmann.

Committee on Narcotics

The Committee on Narcotics and Hazardous Substances of the Illinois State Medical Society met on Friday, September 10 at the Knickerbocker Hotel, Chicago. Joseph S. Skom, M.D., Chairman, convened the meeting and introduced the Committee members present: Drs. R. K. Richards, Jordan M. Scher, Ross Schlich and David M. Slight; the guests: Harold M. Visotsky, M.D., Director of Illinois Department of Mental Health; Mr. Charles Ward and Mr. Larry Slotnik, U.S. Bureau of Narcotics; Father Bruce Wheeler, House of Correction; Representatives James Moran and Nicholas Zagone; Thaddeus Kostrubula, M.D., Director of the Chicago Department of Mental Health; and Robert Cook, M.D., Illinois Department of Mental Health; and the ISMS staff: Mr. Paul Swarts and Mr. Roger White.

The subject of educational material as initially explored at the July 16 meeting was reviewed. The effectiveness of a pamphlet designed to acquaint young people with the hazards of drug experimentation and addiction was discussed and it was pointed out that such presentations are evidently unsuccessful in that they do not reach the desired audience. A public information program was proposed to present a realistic image of the narcotic addict in contrast with the grossly distorted image presently conveyed.

Narcotic legislation of the 74th Illinois General Assembly was reviewed. Representatives Moran and Zagone explained

their roles in seeking to combat narcotic addiction by specific legislative action.

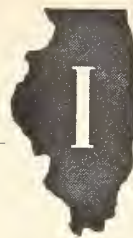
Representative Moran, sponsor of the Drug Addiction Act, outlined the objectives and statutory features of the bill, which is a means of achieving sound programs for the care, treatment and rehabilitation of narcotic addicts. The Narcotic Advisory Council, established by the act, will study the problem in its total perspective, with particular reference to Illinois, and propose recommendations to the Department of Mental Health for the development of programs and to the 75th Illinois General Assembly for legislative action.

The point was emphasized that "special research" is needed into the various facets of narcotic addiction. Problem area "task forces" were proposed. As the necessary organization for building task forces is presently inadequate and the extent of co-operation is unknown, it was decided that the narcotics conference would be the most appropriate presentation. Specialized task forces would evolve from the conference to work on specific problems as indicated.

As prime sponsor of the conference, the Illinois State Medical Society would bring together the various disciplines involved in narcotic addiction. The conference goal will be an interdiscipline exchange working through a multilateral approach. The function of the conference would be to pump information into the audience in order to stimulate interaction among the disciplines represented, resulting in the exploration of care, treatment and rehabilitation of narcotic addicts.

Attendance at the Conference will be by invitation. Special groups, such as physicians, pharmacists, social workers, law enforcement people, vocational rehabilitation personnel, will be invited and each organization will be requested to send representatives. A modest registration fee will be imposed. A special program committee was constituted to structure the program of the conference and arrange the format.

The next meeting of the committee will be held October 15, 1965 at the Knickerbocker Hotel.



Mt. Sinai Opens Pain Clinic

A pain clinic has been opened at Mount Sinai Hospital Medical Center to treat patients with severe, intolerable, unrelenting pain that has not been relieved by any of the usual methods of treatment, and to conduct research into the nature, measurement and treatment of pain.

In announcing the opening of the clinic, Solomon Katz, president of the medical center, stated that the Mount Sinai clinic is the only one in the area concerned with both the medical and psychological handling of chronic pain. (Other pain clinics are primarily concerned with testing the effectiveness of various anesthetic agents and procedures.) Facilities of the pain clinic are available to outpatients and hospitalized patients.

Patients treated at the Mount Sinai clinic will include those with spreading cancer, burns, gangrene of the foot, certain degenerative diseases, disabling back injuries, and pain of a psycho-physiologic origin.

According to Dr. Eric C. Kast, director of the clinic and a member of the department of medicine at the hospital, and assistant professor of medicine and psychiatry at the Chicago Medical School, three per cent of the patients under medical care have chronic pain which is not relieved by any of the standard methods of treatment.

Different methods are used, either together or in varying combinations, to alleviate the patient's pain. These may involve the use of drugs, including the new hallucinogenic drugs, hypnosis, anesthetic blocks, surgical procedures such as specific nerve cutting, and psychotherapy.

Much remains to be learned and a considerable part of the work in the clinic will be devoted to research into pain.

Radiation Hazards Booklet Available

Copies of the "Rules and Regulations for Protection Against Radiation Hazards" as amended in September, 1964 are available from Dr. Franklin D. Yoder, Director of the Department of Public Health, State Office Building, Springfield. The booklet contains all the information that users of ionizing radiation need to comply with the Illinois Radiation Protection Act.

Chest Physicians Announce 1966 Essay Contest

The American College of Chest Physicians offers three cash awards to be given annually for the best essay prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest disease (heart or lungs).

The First Prize will be \$500; Second Prize, \$300 and Third Prize, \$200. Each winner will also receive a certificate of merit. A trophy inscribed with the name of the winner and the name of his school will be presented to the winner's school.

Since these Essay Contests were initiated in 1950, cash prizes totaling more than \$13,000 have been awarded to students in many parts of the world.

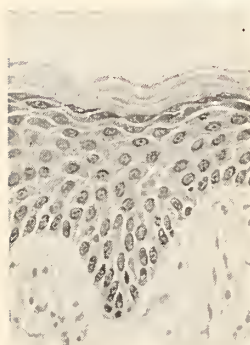
The winners will be announced at the 32nd Annual Meeting of the American College of Chest Physicians, to be held in Chicago, Illinois, June 23-27, 1966.

The official application form, sample copies of the journal, and additional information may be secured by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 60611.

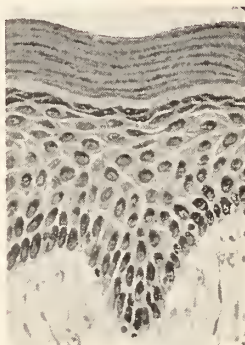


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- Six times the LD₅₀ of methoxsalen—only half the dosage of methoxsalen, due to 2X activity.
- No liver function test required.

CONTRAINDICATIONS: Diseases associated with photosensitivity, such as porphyria, acute lupus erythematosus, or leukoderma of infectious origin. To date, the safety of this drug in young persons (12 and under), aphakic people, pregnant women, or women of child-bearing age has not been established and is, therefore, contraindicated.

DOSAGE: Adults and children over 12 years: two tablets daily as directed in brochure.

SUPPLIED: Bottles of 28 and 100 coated tablets. Also available: Oxisoralen Lotion when the natural botanical is preferred.



References: (1) Becker, Jr., S. W.: J.A.M.A. 173: 1483-1485, 1960; (2) Pathak, M. A., and Fitzpatrick, T. B.: J. Invest. Dermat. 32:509-518, 1959; (3) Pathak, M. A., Fellman, J. H., and Kaufman, K. D.: 33:165-183, 1960.

Write for literature and clinical supply of Trisoralen.
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NEWS and ANNOUNCEMENTS (cont'd)

Ocular and Adnexal Tissue Diagnostic and Reporting Services

Free diagnostic and reporting services on ocular and adnexal tissue are now available at the Max Goldenberg Eye Pathology Laboratory of Michael Reese Hospital and Medical Center, it was announced by Dr. Manuel L. Stillerman, chairman of the Department of Ophthalmology.

The laboratory will provide a photograph of the gross material, colored photomicrographs of unusual sections, and two histopathological preparations to the contributor and, if requested, to the pathologist at his institution.

All services of the laboratory, which is under the direction of Dr. Robert Levine, are free.

For kits write: Max Goldenberg Eye Pathology Laboratory, Michael Reese Hospital and Medical Center, 29th St. and Ellis Avenue, Chicago, Illinois 60616.

Opened in July, 1964, the Max Goldenberg Eye Pathology Laboratory also conducts programs of teaching and research.

Appointments

Dr. Max K. Horwitt, professor of biological chemistry at the University of Illinois College of Medicine, is one of two United States scientists appointed to a United Nations group studying nutrition.

The expert group of 12 scientists from 10 countries will meet in Rome September 6 to establish standards for human vitamin requirements. Jointly sponsored by the U.N. Food and Agriculture Organization and the World Health Organization, the group will attempt to achieve a greater measure of international uniformity in the nutrition field.

In addition to his research and teaching at the college, Dr. Horwitt is director of the L.B. Mendel Research Laboratory for the Department of Mental Health.

He founded the laboratory in 1937 at the

NEWS and ANNOUNCEMENTS (cont'd)

Elgin State Hospital, Elgin, Illinois, one of many institutions to establish facilities for nutritional control at Dr. Horwitt's urging. For his service to the field of nutritional science, Dr. Horwitt won the Osborne and Mendel Award.

A biochemist, he received his doctorate from Yale University where he was also a research fellow in physiological chemistry.

Dr. John W. Curtin, clinical associate professor of surgery and head of the Division of Plastic Surgery at the University of Illinois College of Medicine was recently appointed vice-president of the American Cleft Palate Association.

Dr. Curtin, who is the attending plastic surgeon to the University's Cleft Palate Center, also serves as associate attending plastic surgeon at Presbyterian-St. Luke's Hospital and attending plastic surgeon to the West Side Veterans Administration Hospital.

He is a consultant in plastic surgery at the Chicago Municipal Tuberculosis Sanitarium and the Chicago State Tuberculosis Sanitarium, and for the Great Lakes Naval Hospital and the Chicago, Rock Island and Pacific Railroad.

Henry B. Betts, M.D., was named Medical Director of the Rehabilitation Institute of Chicago. A specialist in physical medicine, Dr. Betts has an extensive medical background that includes a fellowship with the National Foundation for Infantile Paralysis at Columbia Presbyterian Hospital, New York.

Dr. Betts was appointed associate medical director of the Rehabilitation Institute in February, 1964 and was selected by Governor Kerner's Committee on Employment of the Handicapped as "Physician of the Year." He also teaches the specialty of physical medicine as assistant professor, Northwestern University Medical School.

The alcoholic *CAN* be rehabilitated

With a unique background of 80 years' experience, The Keeley Institute has earned an international reputation as a specialized hospital for the *restorative treatment* of the "problem drinker."

Our progressive, well-rounded regimen includes:

- gradual withdrawal
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Individual and group care are conducted in a friendly, cooperative atmosphere under the direction of physicians and experienced personnel. *We take female as well as male patients.*

Write for detailed, descriptive information on our low cost, comprehensive services—or phone 815 584-3001. We welcome your referrals.

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Starting Dates — 1965

SPECIALTY REVIEW COURSE IN GYN-OB,
Two Weeks, October 25
SPECIALTY REVIEW COURSE IN SURGERY,
Part I, November 8
SPECIALTY REVIEW COURSE IN ORTHOPEDICS,
November 29
SPECIALTY REVIEW COURSE IN MEDICINE,
Part II, November 29
SURGERY OF FACE & MOUTH, One Week, October 11
BLOOD VESSEL SURGERY, One Week, October 25
UROLOGY, Two Weeks, October 25
GENERAL SURGERY, One Week, November 1
ARTERIOGRAPHY, Four-Days, November 2
SURGERY OF COLON & RECTUM, One Week, November 15
GALLBLADDER SURGERY, Three Days, November 15
SURGERY OF HERNIA, Three Days, November 18
MANAGEMENT OF COMMON FRACTURES,
One Week, November 8
FRACTURES IN CHILDREN, One Week, November 15
OBSTETRICS, General and Surgical, Two Weeks, November 8
BASIC INTERNAL MEDICINE, Two Weeks, November 1
ADVANCES IN RADIOGRAPHY, One Week, November 15
ADVANCED COURSE IN HEMATOLOGY, One Week, October 18
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

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Phone: (AC 313) 663-5522**



NEWS and ANNOUNCEMENTS (cont'd)

Grants

The University of Chicago has received a \$5,000 unrestricted grant for eye research from Research to Prevent Blindness, Inc. (RPB).

The grant brings the total of such RPB awards to the University's Section of Ophthalmology to \$30,000 over the past six years.

RPB is a national voluntary organization which supports scientific research aimed at finding and eradicating the causes of blinding diseases. Since 1960 it has made annual unrestricted grants totalling \$650,000 to 29 research institutions across the country.

Dr. Frank W. Newell, Chief of the Section of Ophthalmology and Professor of Ophthalmology at the University of Chicago, said that the funds awarded by RPB provide the research director with maximum flexibility in his investigations.

Dr. Robert Y. Moore, Assistant Professor of Medicine and Anatomy at the University of Chicago, has received a John and Mary Markle Foundation grant of \$30,000.

The grant, covering a five-year period, will enable Dr. Moore to study training methods in pediatric neurology. In addition, the Markle Scholarship will allow him to obtain further experience in research.

The John and Mary Markle Foundation each year awards 13 to 25 Markle Scholarships. The awards may be used in any way which will contribute to the recipient's advancement as a member of his institution's faculty. The purpose of the program is to improve medical education and research.

Dr. Moore received his B.A. degree from Lawrence College in 1953. He received his M.D. degree from the University of Chicago in 1957 and a Ph.D. degree from the University in 1962.

He was appointed an Instructor in Anatomy and Resident in Medicine (Neurology) at the University of Chicago in 1959. In 1964 he was appointed an Assistant Professor of Medicine (Neurology) and Anatomy at the University.

Forest Hospital

is an intensive care facility noted for its advanced, comprehensive treatment programs. One such program is the adolescent service, which provides psychotherapy for girls and boys from 13 through 17. Accredited school facilities are on campus. Parents of children in treatment receive therapy and social work follow up. A game room, swimming pool, recreational activities are offered in a total setting designed to speed recovery. A psychiatrist specializing in adolescence is in charge.

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Meeting Memos



October 23-28—The American Academy of Pediatrics will hold its 34th annual meeting at the Palmer House, Chicago.

General session panels and symposiums will deal with carbohydrate metabolism; teenagers; recent epidemics (including encephalitis and rubella); bases of child development; recent developments in pediatrics; and antimicrobial agents.

Several special reports will be given, including one on Project Head Start and one on the Food and Drug Administration by Joseph F. Sadusk, Jr., M.D., director of the FDA.

The academy meeting is open to physicians who are not pediatricians. Interested physicians may write to the American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois for more information.

October 27—The Mount Sinai Hospital Medical Center and the Schwab Rehabilitation Hospital are co-sponsoring the Dr. Gusta Davidsohn Lecture: "Another Look at Rehabilitation." The lecture will be given at 8:00 p.m. in the Leopold Kling Auditorium, 2730 West 15th Place, Chicago, by Jerome S. Tobis, M.D., Chief, Division of Rehabilitation Medicine, Montefiore Hospital and Medical Center; and Professor of Rehabilitation Medicine, Albert Einstein College of Medicine.

November 12—The Diabetes Association of Greater Chicago will conduct its eighth annual Symposium on Diabetes at the Bigler Auditorium, Children's Memorial Hospital, 707 West Fullerton, Chicago, with registration beginning at 8:30 a.m.

The morning session will be devoted to a symposium on current definitions of the disease, including electron microscopical,

biochemical, endocrinological and clinical redefinitions, followed by a panel discussion. In the afternoon there will be a presentation on the prevalence and epidemiology of diabetes, a discussion of psychiatric aspects and a paper on juvenile diabetes and some of the inferences that may be drawn from work in this area.

Registration is free for members of the Diabetes Association of Greater Chicago or the American Diabetes Association and for medical students and resident house staff members. The fee for non-members is \$25.00. Members of the Academy of General Practice may claim hour for hour credit in Category II. Inquiries should be addressed to the Diabetes Association of Greater Chicago, 620 North Michigan Avenue, Chicago 11, Illinois.

November 12-13—The Cook County Graduate School of Medicine will conduct the first International Symposium on Ocular Cryosurgery, immediately prior to the annual meeting of the American Academy of Ophthalmology and Otolaryngology.

The chairman will be Dr. John C. Bellows, Professor of Ophthalmology, Cook County Graduate School of Medicine and Associate Professor of Ophthalmology, Northwestern University Medical School. Participating in the Symposium will be Dr. Tadeusz Krwawicz of Poland (originator of cryoextraction techniques); Dr. S. P. Amoils of Johannesburg, South Africa; Dr. Alic McPherson, of Houston; A. P. Rinfret, Ph.D., of Tonawanda, N. Y.; Dr. K. Rubinstein, of Birmingham, England; Dr. Michael Shea, of Toronto, Canada; and Dr. David Sudarsky, of New York City.

For details, write the Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago 60612.

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OBITUARIES

Alf S. Alving*, Chicago, died May 18, aged 63. A graduate of the University of Michigan Medical School, Ann Arbor, in 1927, he specialized in internal medicine.

Edgar Austin, Florida, formerly of Golconda, died August 1, aged 85. A graduate of the University of Louisville School of Medicine in 1909, he specialized in internal medicine. He served on the committee which started the South Florida Baptist hospital and was a charter member of the board. He also served as the County Health Physician and was Plant City physician.

Stanford T. Bolstead*, Chicago, died September 24, aged 79. He was a graduate of Loyola University School of Medicine in 1918 and was a staff member of Norwegian-American hospital.

Martin H. Breiter, Des Plaines, died August 13, aged 83. A graduate of Bennett Medical College in 1914, he practiced in Chicago for over 50 years.

Joseph P. Crabtree*, Elmhurst, died August 5, aged 65. In 1927 he was a graduate of the University of Illinois College of Medicine.

Isadore B. Diamond*, Chicago, died September 12, aged 92. A graduate of Atlanta School of Medicine in 1894, he began to specialize in neurology and psychiatry in 1926. He retired in 1954 after serving on the board of the Chicago Psychiatric Hospital. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Peter J. Doretto*, Chicago, died August 22, aged 68. He was a graduate of Loyola University Medical School in 1925 and former staff president of St. Mary of Nazareth hospital.

Teodor H. Elias*, Chicago, originally from Poland, died August 17, aged 46. He was a graduate of Facolta di Medicina e Chirurgia dell'Universita di Bologna, Italy, in 1951.

Rocco J. Fazio*, Chicago, died September 15, aged 59. A graduate of Loyola University School of Medicine in 1932, he was former past president of the Medical Staff of St. Bernard's hospital.

Feliciano A. Hicaro, Chicago, died August 31, aged

69. A graduate of Chicago Medical School in 1930, he was a staff member of both Mother Cabrini and Oak Forest hospitals.

Marcus H. Hobart*, Evanston, died September 25, aged 76. In 1915 he was a graduate of Northwestern University Medical School and he served as assistant professor of orthopedic surgery at the Illinois Medical School and also as assistant professor of surgery at Northwestern. He was president of the Chicago Orthopedic club and a member of the American Academy of Orthopedic Surgeons as well as being an emeritus member and a member of the Fifty Year Club of ISMS.

Frank E. Hruby, Chicago, died August 25, aged 69. He was a graduate of the University of Illinois College of Medicine in 1927.

Charles H. Johnson, California, a Woodlawn physician for 50 years, died September 1, aged 82. A graduate of the Chicago College of Medicine & Surgery in 1908, he specialized in E.E.N.T. and retired in 1956.

Casimir V. Kierzkowski, Marion, originally from Germany, died August 21, aged 56. A graduate of Marquette University School of Medicine, Milwaukee, in 1933, he was a staff member of the V.A. hospital in Marion.

David Levitin*, Glencoe, died August 17, aged 53. A graduate of Rush Medical College in 1933, he specialized in psychiatry.

Harry E. McCord, Texas, formerly of Mattoon, died August 16, aged 81. A graduate of the University of Cincinnati College of Medicine in 1907, he retired in 1955.

Lonel H. Neff, Dwight, died August 4, aged 61. A graduate of Loyola University School of Medicine in 1929, he specialized in dermatology.

Perry A. Olden, Chicago, died August 18, aged 84. He was a graduate of Howard University College of Medicine, Washington, D.C., in 1914.

George O. Webster*, Jacksonville, died August 20, aged 86. A graduate of St. Louis University School of Medicine in 1904, he was an emeritus member and a member of the Fifty Year Club of ISMS.

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Illinois Medical Journal

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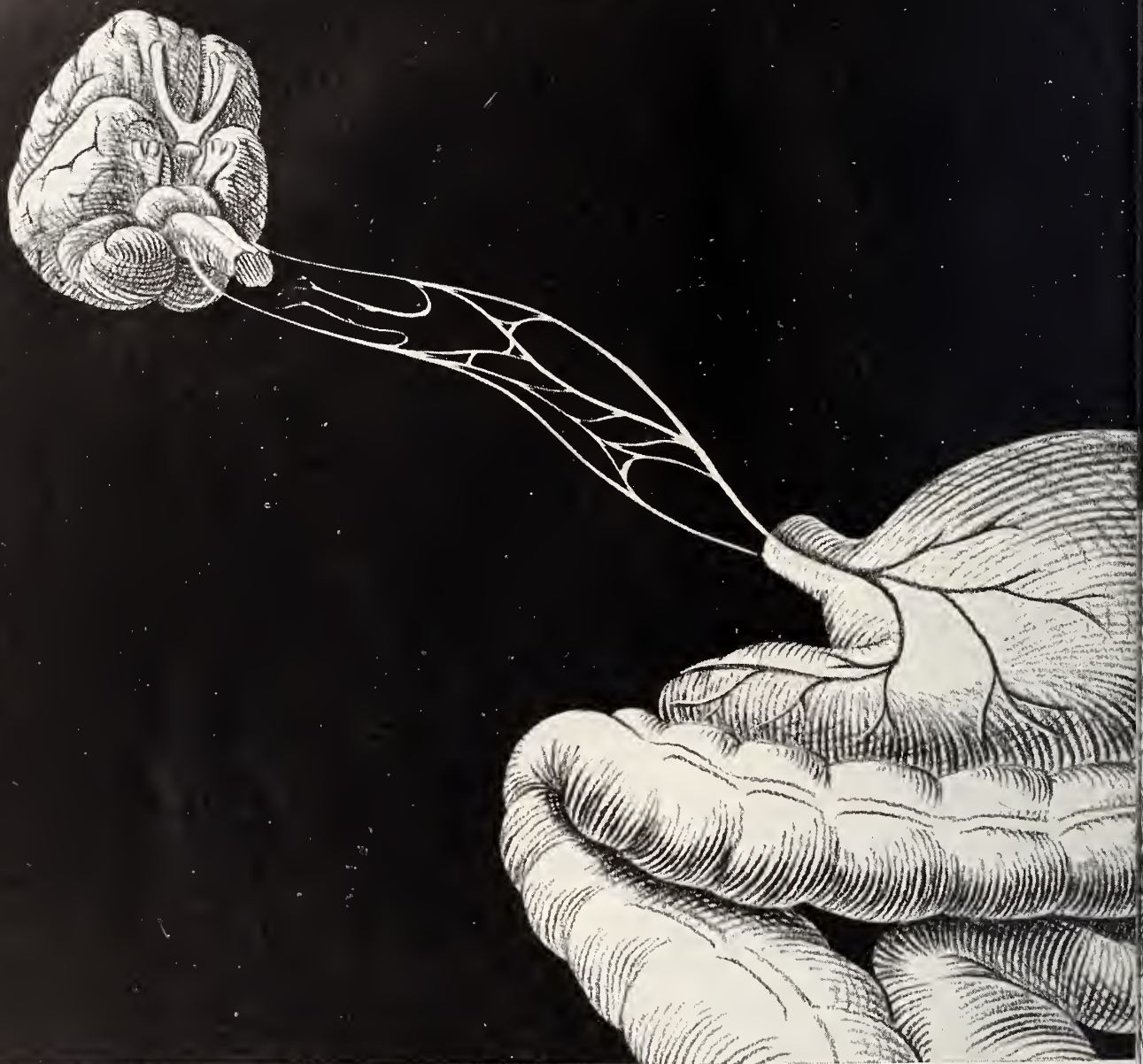
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References: 1. Kemp, J. A.: Antibiotic Med. & Clin. Therapy 6:534 (Sept.) 1959.
2. Winkelstein, A.: Am. J. Gastroenterol. 32:66 (July) 1959.



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Illinois Medical Journal

volume 128, number 5

November, 1965

WHAT MEDICARE IS ALL ABOUT

Burtis E. Montgomery, M.D.

President, Illinois State Medical Society

THE OFFICIAL NAME of Public Law 89-97 is the "Social Security Amendments of 1965." I mention this because it is important to recognize that, although the "Health Insurance for the Aged" program, known to the newspapers as "Medicare," has received the most attention from the press and from the medical profession, it is far from the whole of this law.

I do not plan to go into detail on most of these changes. Considering that the published text of the law takes up one hundred and thirty-eight closely printed pages, I doubt that I could go into detail without taking a far longer time than I am allowed. However, to indicate the extent to which this bill affects our national life, I do want to simply list some of the non-medical elements of this legislation, before taking up in detail Title One of the law—the health insurance and medical assistance programs.

Title II

The second section of the law, (Title Two—Other Health Care Amendments) enlarges the maternal and child health and crippled children's programs. It aims at making these services available on a state-

wide basis by 1975, authorizes grants for training professional personnel for care of crippled children and requires payment of reasonable cost for hospital services in these programs after June 1967.

In addition, it authorizes a new grant-in-aid program, to state and local health agencies, medical schools, and teaching hospitals, for comprehensive projects for health care of school-age and preschool children.

It authorizes more funds for planning mental retardation programs.

It authorizes, for the needy aged, monthly cash grants and payments for care if they are in institutions for TB or mental care. Previously, no cash grants were authorized for these aged needy for Federal-state as-

Editor's note: "What Medicare is All About" is a speech originally delivered by Dr. B. E. Montgomery October 14 as part of an 8th District Postgraduate Program in Champaign, Illinois. Because we feel that the contents of this speech are so vital to members of the Illinois State Medical Society, we are reprinting it in its entirety in place of the usual President's Page.

sistance programs, and medical care payments were authorized for a maximum of 42 days and only when the TB or mental illness was being treated in a general hospital or nursing home.

Up till now, the aged needy could not receive Old Age Assistance (cash grant) and Medical Assistance for the Aged (medical care) during the same month. After 1965, the aged recipient can receive aid under both programs during the month he enters or leaves a hospital or nursing home.

A new grant program is authorized, to finance studies of diagnosis, prevention, and treatment of emotional illness in children.

Title III

The third section (Title Three—Social Security Amendments) deals with changes in the Social Security retirement and disability program. There are changes in all aspects of this program—eligibility, payments, taxes. I shall indicate only some of the more significant changes.

One of the most significant to the medical profession is that Social Security coverage is now compulsory for self-employed physicians. For physicians, this coverage and liability for taxes begins with the current year; the self-employed physician will pay 5.4 percent Social Security tax on 1965 earnings, up to \$4,800. On 1966 earnings, the tax base rises to \$6,600 and the tax rate to 6.15 percent.

There are other eligibility changes. Children who are fulltime students may receive dependents' benefits until the age of 22; widows may begin receiving reduced benefits at 60 (instead of 62), and a divorced woman over 62 is entitled to a wife's or widow's benefits under certain conditions. An aged widow or widower does not lose all claim to survivor benefits when he or she remarries.

The tax base for all covered under Social Security will be raised from \$4800 this year to \$6,600 next year. Tax rates for both the self-employed and for employers and employees are also increased.

In the disability benefit program, the definition of "disability" has been changed

so that a disability no longer has to be of long-continued and indefinite duration, but must last—or be expected to last—for at least twelve months. This is a rather significant shift—from a program of benefits for permanent and total disability to one covering semi-permanent and total disability.

In addition, some of the disability benefit funds can now be used to pay for rehabilitation services for those entitled to disability benefits.

Minimum cash benefits under social security are increased, retroactive to the beginning of 1965, as are the monthly payments for all currently receiving benefit checks. Checks were mailed in September, making lump-sum payments of the difference between the old and new rate from January to August.

When the new tax base goes into effect next year, maximum benefits will also rise for those paying tax on earned income over \$4,800. However, since social security benefits are calculated on the basis of average earnings over a number of years, these maximum benefits will not be generally payable for some years.

Title IV

The fourth section of the law (Title Four—Public Assistance Amendments) makes changes in the federal-state programs which provide monthly cash assistance to the needy aged, blind, disabled, and families with dependent children. In general, these provisions increase the federal share of the cost of these programs and permit states to disregard certain amounts of earned income in determining eligibility for aid. This provision can be an incentive to the needy to seek work and attain some degree of self-support, since they will be able to increase their income by working—instead of having every dollar they earn cut a dollar off their assistance check.

Title I

As you can see, this law has an impact on the whole framework of federal and state social welfare programs—increasing both taxes and benefits, adding new pro-

grams, and extending benefits to more recipients.

The section which will have the greatest impact on medical care in this country is, of course, the one which has received the most attention in the press—Title One, Health Insurance for the Aged and Medical Assistance. Three new programs go to make up this section—the hospital insurance program for the aged (those 65 years of age and over), the supplementary medical insurance program for the aged, and a federal-state program of assistance to the medically needy which can eventually affect care for all age groups.

You are well aware that the medical profession opposed the passage of the health insurance program for the aged. It was our firm and reasoned belief that this program would retard rather than promote the science and art of medicine and the betterment of the nation's health.

The debate is over. Congress has made its decision. It has extended Social Security to cover the cost of hospital care for the nation's aged, and has offered everyone over 65 a federal program to help meet medical expenses, with premiums shared by the individual and the Treasury.

Our task now is to seek a clear grasp of these programs and their limitations, so that our present effective patterns of medical care will suffer the minimum damage. It must be recognized that many questions concerning this program cannot yet be answered. Despite the amount of detail regarding the program contained in the law itself, many of the fine points of administration (as in any federal program) must await the development of regulations by the federal agencies which will administer the program.

With this in mind, let us turn to the actual details of the program, as spelled out in the law.

Health Insurance Programs

The health insurance program consists of hospitalization and related care, under social security, for almost every American aged 65 and over, whether or not he is otherwise covered by social security, and of an optional program which will cover

certain medical expenses. Again, almost every aged American is eligible for this medical program, but coverage is voluntary with the individual; he pays half of a regular premium charge and the federal government pays the other half.

Payments for care under both these programs do not begin until July 1966. This is important; any health insurance the aged individual now holds should be retained until at least that date, so he will be covered in the interim. During this period, he can also review the benefits of the federal program, and decide whether he wishes to retain a modified non-governmental health insurance policy, to supplement these benefits.

Hospital Insurance

Let us focus our attention first on the hospitalization portion of the program. We find it covers services by hospitals, post-hospital care in a nursing home, and home health care after release from the hospital or nursing home.

Does it cover the total stay in a hospital or nursing home, no matter how long recovery takes?

Does it pay the total cost of services covered?

The answer to both these questions is "No."

The program covers only 90 days of hospital care and 100 days of nursing home care in each "spell of illness." Each spell of illness (or benefit period) begins after the aged person has been out of a hospital or nursing home at least 60 consecutive days.

The hospital services covered include all those usually provided to inpatients. Payment is not made for private-duty nursing, nor for the full cost of a private room, unless medically indicated. No payment under this program is made for physicians' services—except for the services of residents and interns in training.

The patient pays the first \$40 of the hospital bill. After 60 days of hospitalization, he pays \$10 for each additional day up to the 90th day. Similarly, the plan meets the full cost of care in a nursing home or

other "extended care" facility only for the first 20 days. After the 20th day, the patient must pay \$5 per day of the cost of care.

Nursing home coverage is available only when the patient enters the home after having been hospitalized at least three days. It is important to note, also, that while the hospital insurance program begins July 1966, coverage of nursing home care does not begin until January 1967.

Two other services are covered under this program. It will meet the cost of up to 100 home health visits a year by a nurse, a therapist, or a home health aid. This care, too, must follow discharge from a hospital or from a nursing home. The patient must be under a physician's care, and under a home health care plan established by the physician.

The program also meets part of the cost of hospital outpatient diagnostic services. It covers laboratory and other studies; the patient pays the first \$20, plus 20 percent additional charges for studies furnished by the same hospital during a twenty-day period.

Hospitalization for mental illness is also covered, but with special limitations; only a total of 190 days such care is covered in an individual's lifetime. Care in Christian Science sanatoria is also covered as hospital care.

Payment for services, except in emergencies, will be made only to institutions and agencies which meet federal standards. These are not, as yet, fully defined, but they will include utilization review plans, transfer agreements between hospitals and nursing homes, and 24-hour nursing service in the nursing homes. The institution must accept as full payment the "reasonable cost," which will also be determined by federal standards.

Medical Insurance

Unlike the hospital insurance program, which covers almost all the aged automatically, each aged individual has a choice of whether he will participate in the medical insurance plan. Those who enroll will pay a \$3 premium; for those on Social Security,

this will be deducted from their monthly checks—for those who are needy, it may be paid by the state welfare agency.

Besides the \$3 monthly premium, the beneficiary must pay the first \$50 of his medical bills each year, and 20 percent of the cost of services covered by the program.

Here is what the plan includes:

Payment for physicians' and surgeons' services, wherever provided; up to 100 home health visits each year; diagnostic x-ray and laboratory tests, and other laboratory procedures; x-ray and radiation therapy; ambulance services; and surgical and prosthetic supplies. Other dental work, prescription drugs, eyeglasses, and hearing aids are not covered, nor are physicians' services when not part of treating a specific complaint (for example, general physical examinations).

Part of the cost of outpatient psychiatric treatment is included, up to a maximum federal payment of \$250 per year.

In this program, too, the payment is based on federal determination of the "reasonable cost" of services; the insurance payment will consist of 80 percent of this reasonable cost.

The first enrollment period has already begun, for those over 65, and will continue through the end of March 1966. Those who are not 65 now may sign up during the three months before they are 65 and four months after. Those who do not enroll during their initial enrollment period will have to pay a higher premium than the initial \$3 rate; those who drop out after enrollment will have only one more chance to re-enroll.

How these two programs will be administered is still under consideration in Washington. There is a strong probability that private insurance companies and prepayment plans will play a large part in the administration of both programs—but as agents of the federal government, paid to help develop schedules of "reasonable costs" and to handle claims.

The law is complex, and the undertaking a vast one. We are far from knowing all its details and effects. However, I think

it is important to reemphasize that it does not meet *all* medical and hospital costs for the aged, and that it does not begin until July 1966. The most valuable advice we can give the aged is to hold onto any health insurance they have during the transition period—and perhaps even beyond.

Medical Assistance

Finally, let me take a few minutes to discuss the other part of Title I of this law, a part which to date has received little attention but can eventually be of even greater importance to Americans of all ages. This is a new federal-state grant program, to assist those who cannot afford the full cost of needed medical care. It is called Medical Assistance.

For the past thirty years, the Federal government has been reimbursing the states for a part of the cost of aid to the needy aged, blind, and families with dependent children; for fifteen years, it has also been helping to finance state programs for the permanently and totally disabled. These programs initially provided only cash grants to the needy, but since 1950 they have also included, to varying degrees depending on the individual state, payment for medical and related services provided these needy people. Last year, over a billion dollars was spent on medical care through these programs.

This law sets up a new Medical Assistance program, to replace the separate medical care programs for the four groups of assistance recipients. Today, a state can provide different medical services to the needy in the four categories; it can, in fact, provide medical services to one group and not to another. When it establishes a Medical Assistance program, it must make the same medical and related services available to all the needy, aged, blind, disabled, and families on its cash assistance rolls.

The new Medical Assistance program is optional with the states until 1969; until the end of that year, they can start the new program or keep the separate programs they now have. But, beginning in 1970, this is the *only* program through which federal

funds will reimburse these state medical care expenditures for the needy. In view of the states' present commitment to care of the needy—in excess of a billion dollars a year—and a federal reimbursement of 50 to 83 percent, depending on the states' income level, with no dollar limit on the federal share, most states are almost certain to switch to this program.

Some, in fact, have already passed the necessary state legislation to authorize the program.

But this program goes beyond simply consolidating medical care programs for the four assistance categories and providing them with uniform benefits. It requires, so far as Medical Assistance is concerned, that there be no residence requirements, that children's responsibility for support of their parents not be considered in determining eligibility, that comparable income standards for determining eligibility apply to all recipients.

It also requires aid to the medically indigent in these categories, by demanding flexible income standards which weigh the applicant's resources against the cost of needed care. By mid-1967, it will require each state with a Medical Assistance program to include inpatient and outpatient hospital services, physicians' services wherever rendered, skilled nursing home care, and x-ray and laboratory services.

Finally, the state must, if it is to continue receiving federal matching, gradually expand this Medical Assistance program so that, by July 1975, it is assisting in financing comprehensive care to all those in the state, whether in the four categories or not, who fall within the income and resources level set for eligibility.

This is, potentially, a program whereby *anyone* in the United States, regardless of age, could receive aid in paying for *any* care he needed, to the extent he could not pay for it. How this program will be implemented, how many states can afford to implement it fully, we do not know.

We do know, however, that it has almost no legislative limitations as to the services which could be included or as to the individ-

uals who could be aided. By 1975, the sole criteria for eligibility could be the individual's ability to pay.

This program, though it has not had the publicity of the health insurance program for the aged, could well have as great an impact on the financing of medical care in this country—or greater. The aged number only 19 million; the whole nation is

potentially eligible under this program, because each of us *could* encounter a medical expense beyond his ability to pay.

Public Law 89-97 is the start of more than one new pattern in medical care financing. I cannot predict the final pattern—but this crowded blueprint of the law may make at least the beginning of the patterns clearer.

SMALLPOX AMONG HOSPITAL PERSONNEL

In this age of supersonic air travel between continents hospitals throughout the nation are facing a new hazard—the threat of a case of imported smallpox spreading because of lack of immunity.

A study on smallpox immunization among hospital personnel is contained in the October 1 issue of "Hospitals," Journal of the American Hospital Association. This study is a phase of the continuing campaign by AHA to encourage all member hospitals, and all hospitals generally, to maintain a high level of immunization against smallpox, since hospital personnel would be the first to be in contact with a smallpox case detected at the port of entry.

Since 1946, a total of 104 cases of smallpox have been diagnosed and reported in the United States. Eight cases were persons coming into this country from abroad, and the remaining 96 cases resulted from exposure to the 8 introductory cases.

Six member institutions of the AHA are participating in a study to determine the level of immunity against smallpox among personnel and also to explore the best means of achieving and maintaining an adequate level of immunity. Persons who have been successfully vaccinated against smallpox within the last three years are considered having adequate immunity against smallpox.

J. D. Millar, M.D., chief of the smallpox unit, Communicable Disease Center, Public Health Service, Atlanta, points out that smallpox introduced into a hospital will not spread if all individuals exposed to the disease are adequately immunized. Adequate immunity is assured if each individual has been successfully vaccinated and revaccinated at intervals sufficient to keep his level of immunity high.

The spread of smallpox to hospitalized patients is a danger, Dr. Millar said. The only action that could be taken to ensure total protection of patients would be to vaccinate everyone admitted. This is impractical, Dr. Millar added. To solve the problem of possible patient susceptibility, the hospital will have to depend on community efforts to maintain better levels of immunity.

THERE ARE FEW IF ANY DISEASES which have been prey to more speculation, personal opinion and theory than tuberculosis. This is especially true of tuberculosis in children.

Official reports testify to the high tuberculosis mortality rates among infants from birth to one year old during the 19th century. Indeed, Drolet¹ has pointed out in 1868 the New York City Metropolitan Board of Health disclosed that 1191 infants under one year of age died from tuberculosis per 100,000. However, in 1898 the rate was 609 per 100,000. In 1900 the rate was 311.6 for infants up to the age of one year. The disease was often referred to as infantile tuberculosis. Obviously, this term included meningitis, miliary dissemination and tuberculous pneumonia. Inasmuch as most infants were exceedingly ill when first examined and soon died, it was assumed that practically all who became invaded with tubercle bacilli developed this fatal disease. Severe symptoms usually appeared suddenly in those who otherwise had seemed to be in excellent health. Therefore, it was theorized that they suffered and died from primary tuberculosis. It was believed that the infant has "extremely high susceptibility" and "almost no resistance" to tubercle bacilli.

It had long been observed that the number of children who had fatal tuberculosis greatly decreased after the first year of life. In fact, in the United States in 1900 among children from one to four years the tuberculosis mortality rate was 101.8 per 100,000 in contrast to 311.6 among children under one year old.

The lowest mortality rate has been observed among children from five to twelve years of age. In 1900 among the children from five to 14 years the mortality rate was 36.2 per 100,000 while the rate among infants was more than eight times greater.

This marked difference in mortality in these age groups resulted in speculation as to why children after the first year of life develop such "low susceptibility" and such "high resistance" to tubercle bacilli.

Knowledge of tuberculosis among chil-

TUBERCULOSIS AMONG CHILDREN

J. Arthur Myers, M.D./minneapolis

dren was markedly increased when Clement von Pirquet^{2, 3} of Vienna devised a harmless method of testing with tuberculin by applying this substance to a superficial scarification of the skin. Indeed, his work was revolutionary. He found that a high percentage of the apparently healthy girls and boys in Vienna reacted to this test. In fact, among 1407 tested, 5 per cent of the one year olds reacted. The percentage of reactors increased with age to 92 per cent among those of 14 years.

Because of history of contact with communicable cases of tuberculosis, etc., Pirquet was firmly convinced that the reaction to tuberculin indicated the presence of infections with tubercle bacilli. However, incontrovertible proof awaited the court of last appeal conducted by Anton Ghon^{4, 5} who made meticulous necropsies on 184 bodies of children who, before death from various causes, presented no evidence of tuberculosis except the tuberculin reaction. In one of these children his study was not completed, but in the remaining 183 tuberculosis was found. Concerning this, Ghon said, "From the point of view of a pathologist I can therefore state on the basis of

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my own studies, which not only refer to all the cases quoted in the monograph, that I am completely in accord with those who strongly believe in the specificity of the tuberculin reaction."

Veterinarians had established the efficacy of the tuberculin test in cattle 20 years before Pirquet and Gohn found it equally effective in people. Thus, since 1907, we have had an exceedingly accurate test for the presence of tubercle bacilli in the human body. So valuable in fact that it has been designated as the "Master Key" for the eradication of tuberculosis.

In the spring of 1921, an opportunity was offered a group of physicians to study tuberculosis in children. Our Commissioner of Health provided all necessary facilities for such investigation. We had been taught and were teaching that invasions with tubercle bacilli in infancy carried extremely high—almost 100 per cent—mortality. It was also assumed that other current statements concerning tuberculosis among children were based on well-documented studies and were factual. As our work was getting under way, facts were presented by others which were contrary to our beliefs and therefore emphasized the importance of our studies. For example, Krause^{6, 7} observed that the prognosis among apparently healthy infants with invasions of tubercle bacilli as manifested by the tuberculin reaction, is infinitely better than beliefs based on theory, personal opinion, and speculation had indicated. Indeed, he observed that in the City of New York, only one male infant died in every 66 infected with tubercle bacilli. Drolet¹ pointed out that there were probably 13,000 infected infants in New York in 1923, however only 122 died. This indicated that ordinarily the majority of infected infants survive.

Krause on Tuberculosis in the Young

In 1925 the various theories, opinions and speculations pertaining to tuberculosis in young animals and children were discussed by Krause⁸. "Because paper after paper of those appearing on many subjects in tuberculosis avers that young animals are in general inordinately susceptible to

tuberculosis and because many an author easily and lightly solves a knotty problem as it arises with the statement of the assumption, it is particularly desirable to point out on how slender a basis of ascertained fact the assumption is based." At that time Krause⁸ conducted a study of resistance in young and old guinea pigs. The result of these studies is so important that Krause's entire conclusions are quoted.

1. When young and old guinea pigs are infected intracutaneously with relatively small quantities of virulent tubercle bacilli that are equal for all the animals there is an earlier appearance and more vigorous development of tubercle at the site of inoculation and in the regional lymph nodes in the old animals.

2. After infection of this nature and heavy enough to cause generalized tuberculosis in the old animals, both young and old guinea pigs developed essentially the same grade of infection. There was nothing to indicate that the young were more susceptible than the old.

3. When infected subcutaneously with large quantities of virulent tubercle bacilli in equal dosage, a more extensive and progressive involvement resulted in the young than in the old.

4. Since under these circumstances the young received per body weight double the quantity of tubercle bacilli that was in itself sufficient to cause progressive and fatal tuberculosis in the old, it is likely that the more advanced infection of the young was the result of "overdosage."

In 1932 a co-worker, C. A. Stewart⁹ of pediatric fame, reported observations on a large number of children. He said, "For years the opinion has prevailed quite generally that an initial infection by the *Mycobacterium tuberculosis* occurring in infants usually resulted in death and that the prognosis was increasingly unfavorable the younger the age at which a primary infection was experienced. As a rule little or no hope for recovery was entertained when the disease was contracted during the first two or three years of life, and the very young infant was looked upon as having practically no resistance to tuber-

culosis" Stewart said further, "In the light of new information yielded through the employment of the tuberculin test and x-ray examinations, the former consensus that an infant manifests a very weak resistance to tuberculosis is being challenged, and one frequently reads statements in the more recent literature to the effect that the prognosis of tuberculosis in infancy and childhood is not as poor as it was formerly considered to be and not a few studies have been reported indicating that even during the first year of life the ability to withstand and overcome tuberculous infection is at times almost unbelievable."

Our group¹⁰ had the opportunity of observing and re-examining tuberculin reactive children from time to time and at the end of 14 years it was clearly demonstrated that primary types of tuberculous lesions, whether or not they are demonstrable by x-ray film of the chest, rarely result in significant symptoms. Even in those with large primary pulmonary infiltrates and those with marked enlargement of hilum lymph nodes the lesions usually come under control with no outward manifestation to call it to the attention of the children or their associates.

It was then said that the benignity of the lesions was met with such regularity and consistency as to convince us that the first infection type of tuberculosis, even though it appears in the very young child, may reach considerable proportions and is not in itself a serious condition unless secondary complications arise as a result of endogenous superinfections or re-infections. At that time the period of observation of these children was only 14 years. Therefore, "The ultimate prognosis with regard to tuberculosis, however, cannot yet be determined for this group of children until years have elapsed because it will depend upon the number who later develop the re-infection and destructive type of disease." Thus our observations were continued.

In 1944 Torres reported observations¹¹ on 813 children who were found to be reactors between birth and the age of five years. In 102, lesions were found in the lungs which had characteristics of primary

pulmonary infiltrates. In each case the disease came under control without causing illness. Endogenous re-infections occurred and four developed tuberculous meningitis; five generalized miliary tuberculosis; and two tuberculous pneumonia. These 11 (1.35 per cent) died. Eleven others developed extrathoracic clinical tuberculosis but none died.

Observations After 29 Years

In 1963 we reported observations¹² on 750 children who had their first tuberculin reaction recorded before their sixth birthday. Of this number, 139 had been lost to the study, including 25 who had died from non-tuberculous conditions. The remaining 611 were at the mean age of 3 years when they were first found to react to tuberculin. They were observed 17,040 person-years and had attained the average age of 32 years when reported in 1963. Throughout the period of observation 55 (9.03 per cent) of these children developed clinical disease and 33 recovered. Of these 33 (5.4 per cent) the lesions involved the chests of 11, extrathoracic organs of 17, and organs of two systems in five. There were 18 (2.96 per cent) who died from acute forms of tuberculosis including meningitis and miliary dissemination in the pre-antituberculosis drug era. Most likely this is a higher percentage than usually obtained because we reported all children in the age period under consideration who reacted to tuberculin on admission to our clinic regardless of other circumstances. In this group were a few children referred by family physicians because of symptoms which were due to evolving fatal tuberculosis.

Four others died from chronic forms of tuberculosis. One from congenital pulmonary stenosis and pulmonary tuberculosis at the age of 12 in 1939; one from amyloidosis secondary to tuberculosis of the spine at the age of 13 in 1947; one from pulmonary tuberculosis when 17 years old in 1938; and one from pulmonary tuberculosis at the age of 34 in 1952.

Thus, up to the mean age of 32 years, of the 611 children who reacted to tuberculin at the mean age of three years, 556 (90.98

per cent) had escaped clinical tuberculosis.

In 1964 we reported¹³ follow-up studies on 1886 children who were found to be tuberculin reactors, between the ages of 6 and 12 years who had been observed for a total of 51,005 person-years. There were 310 (16.4 per cent) not recently traced. The remaining children were divided into three groups. Group I consisted of 108 who when first tested reacted to tuberculin. They also had tuberculous primary pulmonary infiltrates of such size, position and consistency to cast visible shadows on x-ray films. Nine of these children had died from nontuberculous conditions and eight had not been traced recently. The remaining 91 ranged in age from 32 to 51 years with a mean age of 37.9 years. Four (4.4 per cent) subsequently developed clinical tuberculosis, only one of whom was in the 6-12 years age period. She had tuberculous pleurisy with effusion at the age of 8 from which she made good recovery. She is now 42 years old. Two others were found to have clinical disease at the age of 13 years; one of whom had involvement of the right knee and is now 50 years old. The other died of pulmonary disease when 21 years old. The fourth child who reacted to tuberculin at the age of 12 years presented a clinical pulmonary lesion at 17 years of age and is now 48 years old. Thus of the 91 traced, plus 9 who died from non-tuberculous conditions, the primary lesions resolved without causing significant illness. Only four subsequently developed clinical disease, three of whom were treated successfully in the pre-antituberculosis drug era.

Of the 1583 children in Group II, 26 had died from non-tuberculous conditions and 260 were not located. When traced, the remaining 1247 ranged between 25 and 53 years at a mean age of 40.3 years. Clinical manifestations had appeared in 62 (5.0 per cent) of whom only 10 were in evidence in the age period of 6 to 12 years.

Of the 62 who developed clinical tuberculosis 25 died (18 girls and 7 boys). Ten were under the age of 13 years when clinical lesions were discovered but only two died during this age period. One died

from surgical shock during an operation of the left tuberculous hip joint, at the age of 9 years in 1940. The other one died from tuberculosis of the spine at the age of 10 years in 1926. The remaining 23 deaths occurred in the age range of 14 to 52 years.

Clinical tuberculosis developed in 37 who made good recoveries. The average age when their lesions were first observed was 16.4 years among the girls. Younger than 13 years were: one at nine years (bone); one at 10 years (pulmonary); one at 11 years (lymph nodes); and two at 12 years (pulmonary). The boys were at the average age of 18.2 years when clinical lesions were first discovered.

Group III consisted of 195 children who did not react to tuberculin when first tested, but became reactors at least one year later. Six had died from non-tuberculous conditions and 41 had not been traced. The remaining 148 were at a mean age of 40.2 years. Four of these children presented demonstrable tuberculous primary pulmonary infiltrates which resolved in the usual manner without causing symptoms. Among the 148 recently traced, four presented clinical lesions during the age period 6 to 12 years, of whom one died from tuberculous meningitis at the age of 7 in 1924 and one died from meningitis and miliary dissemination when 10 years old in 1932. Five presented clinical lesions between 13 and 17 years, and two at the age of 20 and after.

Thus, only 15 of the total number of children who were found to be tuberculin reactors between the ages of 6 and 12 years developed evidence of clinical disease during that age period. Only four of these children died, one at the age of 7 from meningitis, one from surgical shock during operation on the spine at the age of 9, one from tuberculosis of the spine and miliary dissemination at the age of 10 years, and one from miliary dissemination at the age of 10 years. Of the remaining 11 who developed clinical lesions between the ages of 6 and 12 years, three had pulmonary lesions of whom one died at the age of 16 and two at the age of 18 years. The eight survivors are in good health at a mean age of 42 years.

It is worthy of note that among the remaining 62 children who subsequently developed clinical disease the lesions did not appear in a large number during any given year. There were seven at the age of 13, three at 14, four at 15, nine at 16, seven at 17, seven at 18, two at 19, four at 20 and 19 thereafter.

In 1965,¹⁴ we reported observations on 46 children who were found to be reactors to tuberculin between the ages of 6 and 17 years, but who had had diagnosis of clinical tuberculosis before our first examination. In 31 (19 girls and 12 boys) the lesions were located extrathoracically. The most frequent attacks had been made on the skeletal system. Among 25 children, a hip was involved in 10; spine in nine; knee in four; and ankle in two. Only three had died from tuberculosis: one boy had milary dissemination when 17 years old; one girl died from a paravertebral abscess and empyema at the age of 21 years; and one boy died from pulmonary tuberculosis at the age of 33 years.

Among the 15 girls and boys who previously had clinical pulmonary disease seven died. Two at the age of 9 years; one at 13 years; one at 16; one at 26 years; one at 28; and one at 31 years. Of the eight who survived, the present age range is from 33 to 50 years with a mean age of 42.6 years.

A report now in press¹⁵ consists of 1172 girls and boys who had their first known tuberculin reaction after their thirteenth and before their eighteenth birthday. They have been observed for 30,099 person-years. There were 228, including 55 who had died from non-tuberculous conditions, who were lost to the study. Thus, 85.2 per cent were traced. These children were classified into three groups. Group I consisted of 21 who had primary pulmonary infiltrates demonstrated by x-ray shadow when they were first examined. Three were not traced, and three had died from non-tuberculous conditions. The remaining 15 have a mean age of 44.9 years. The primary infiltrates resolved in the usual manner without causing illness. One was found to have bilateral renal tuberculosis when she attained the

age of 39 years. She was treated successfully and is now 53 years old.

Group II consisted of 957 children, who had no evidence of disease except the tuberculin reaction when first examined. Forty-six had died from non-tuberculous conditions and 156 were not recently traced. The remaining 755 were at an average age of 14.4 years when first examined and at the mean age of 43.6 years when traced.

Among the children in Group II, 55 developed evidence of clinical tuberculosis. These lesions appeared in 25 between the ages of 14 and 17 years, 10 of whom were 16 years old when the lesions appeared. The remaining 30 developed lesions after the age of 17; four at the age of 18, six at 19, and 20 after the age of 20 years. The oldest was 40.

Group III consisted of 149 girls and boys who did not react to tuberculin when first tested, but later converted at the average age of 14.6 years. Six of these children died from non-tuberculous conditions and 14 have not been traced recently. Of the remaining 129 the present average age is 42.2 years. Fifteen subsequently developed clinical disease, in 10 of whom the lesions were in evidence before the age of 18 years. In the remaining five, one appeared at the age of 18, one at 19, and three later. The oldest was 41 years when clinical disease appeared.

When it became obvious that many young adults were developing clinical tuberculosis—with the first significant symptoms the disease usually was in its last lap—a theory was promulgated to the effect that these individuals had been denied the benefit of tuberculous infection in childhood. This theory was based on the assumption that most children were harboring tubercle bacilli and those who were not lacked “immunity” and were in a hazardous position if infection occurred in adulthood. Therefore, it was firmly believed the serious and usually fatal disease was due to recent infection. However, longitudinal observations revealed that the young adults who had diagnosis of advanced disease on first examination usually had been infected in childhood and that the disease had evolved

slowly without causing symptoms until it was advanced.

Resistance to Tubercle Bacilli

Infants and young children have strong resistance to tubercle bacilli of primary infection. Their defense mechanism promptly focalizes and encapsulates tubercle bacilli of first invasion. This accomplishment is achieved by the defense mechanism operating without interference for the first three to seven weeks after bacilli enter. During this period the encapsulation is so well along that it continues and forms thick walls of fibrous tissue, then of lime and, in about one-fourth of the cases, pure bone. Lesions of primary tuberculosis complexes cause very little destruction of tissues. However, they result in sensitivity of the tissues of their hosts to tuberculoprotein.

After lesions of benign primary tuberculosis complexes are established, Nature paradoxically treats the occasional one as a foreign body by absorbing the capsule and liberating the previously encased tubercle bacilli. These liberated bacilli set up lesions where they find lodgement on sensitized tissues. The body's defense mechanism is seriously handicapped since tuberculoprotein is poisonous to sensitized cells and tissues.

Such endogenous re-infections may occur in 2 per cent or less of infected infants. For example, tuberculous meningitis in the infant is due to endogenous re-infection from primary tubercles in or adjacent to the central nervous system. Miliary dissemination results from primary tubercles which erode through the walls of blood vessels and discharge large numbers of tubercle bacilli into the blood stream. Obviously the total number of such cases reported in any community is dependent upon the number of infants invaded with tubercle bacilli. These acute highly fatal forms, even though they may occur in only approximately 2 per cent of infected infants, are more often seen during the first year of life than in any other subsequent year.

Diagnosis

To date the presence of primary tuberculosis in infants cannot be diagnosed by physicians for the first three to seven weeks of its existence. However, after this period the host's tissues have become so sensitized to tuberculoprotein that tuberculin introduced into the skin results in a characteristic reaction. Apparently this reaction can be elicited as far into the individual's life as tubercle bacilli survive. The *tuberculin test* is superior to all other diagnostic agents in infants and young children in that it detects the presence of the disease within a few weeks after invasions of tubercle bacilli occur. The test is not helpful in detecting endogenous reinfections as these conditions do not immediately significantly change the degree of reaction to tuberculoprotein. However, as they progress the sensitivity of tissues usually decreases, sometimes to the point of being undetectable by the usual doses of tuberculin. Other than this we have observed no evidence that the degree of reaction to tuberculin provides a criterion of extent of disease present or of remote prognosis.

Roentgenograms of the chests of recent tuberculin reactor infants and young children reveal no evidence of the disease in approximately 95 per cent. In the remaining 5 per cent primary infiltrates have size, consistency and location to cast detectable shadows. However, by the shadows alone one is not able to differentiate them from lesions of other diseases. A few years after invasions have occurred, evidence of calcific deposits in pulmonary parenchyma, hilum region or both may be revealed in 20 to 25 per cent on roentgenograms. However, this finding is not pathognomonic since a number of other conditions result in depositions of calcium.

Primary Tuberculosis among Older Children and Adults

Even though the incidence of tuberculous infection may increase among girls and boys after the first year of life, the tuberculosis mortality rate decreases and reaches its lowest ebb in the entire span of life among children of five to 12 years. Meningitis and miliary dissemination occur but

less frequently than among infected infants. This may be due in part to the fact that in this age period children are not so defenseless against the well-meaning but sometimes destructive fondling of their elders. In fact, as they grow older many children resent such acts and thus avoid massive doses of tubercle bacilli.

Chronic clinical pulmonary tuberculosis usually develops in persons with *long standing infections*. This probably is due to the slowness of evolution of such lesions. Thus, among infected infants and children such lesions are rare before the age of 12 years. Thereafter, they make their appearance over a wide range of years.

When *primary tuberculous infections are postponed until adulthood*, they take the same benign course as those acquired in infancy and childhood except that endogenous re-infections resulting in miliary dissemination and meningitis occur less frequently than among primarily infected infants and young children. Tuberculous pleurisy with effusion occurs in the occasional case soon after the tissues are sensitized to tuberculo-protein. Evolution of chronic clinical pulmonary lesions by no means occurs only within the first year or two after the infection, but is spread over many years.

Treatment

More than 40 years ago when we saw evidence of pulmonary lesions on roentgenograms made of chests of infants and young children who reacted to tuberculin, we assumed they represented destructive tuberculosis in an early stage of evolution and therefore should be treated promptly. Although such children were usually symptom-free and appeared in excellent health we believed the demonstrable pulmonary lesions represented destructive tuberculosis in an early stage of evolution and therefore, should be treated promptly by the methods in vogue for more extensive pulmonary disease in adults. Such procedures as sanatorium residence, collapse therapy and all other items thought to be of value were employed and strongly recommended. However, a surprise was in store. Follow-up

observations on these children revealed all of the lesions took a regressive course regardless of how little or how much treatment was administered. By 1935 after 14 years of observation on the same children we were able to divide them into three groups of which one had been treated in a sanatorium, another had the advantage of a special school for tuberculous children and those in the third group had remained at home because their parents refused institutional treatment. No difference was seen in the course taken by these lesions in the three groups.

Although we had strongly recommended our special school for tuberculous children to other cities throughout the nation our work had been based on faith. What we were doing seemed so logical that "certainly it must be important for children everywhere." Paul said, "Now faith is the substance of things hoped for, the evidence of things not seen." (Hebrews Chapter 11, Verse 1) However, time and observation had revealed that faith in our methods of treating demonstrable primary tuberculosis in children had not been justified. We no longer had to depend upon faith for the lack of value of our procedures was in clear view. The established facts must be transmitted to others. Therefore, on June 27, 1935, we went before the 31st Annual Meeting of the National Tuberculosis Association held at Saranac Lake, New York, presented our findings and announced that we had recommended the closing of the school for tuberculous children and advised against the operation of such schools elsewhere. Thus, it had become obvious that primary tuberculosis in children was not influenced by the methods of treatment then in vogue.

We had long lamented the fact that no germicidal drug was available for administration soon after children were invaded so as to destroy all tubercle bacilli. Hope brightened when Feldman et al¹⁶ proved that Disodium p,p'-Sulfonyl-dianiline-N, N'-diglucoside disulfonate (Promin) is unequivocally effective in suppressing experimental tuberculosis induced by human type of tubercle bacilli. The findings were so

promising that in the fall of 1940, we strongly considered administration of Promin to recent tuberculin convertor children with or without roentgenographic manifestations. However, because of its toxicity and later proved failure as a germicide the proposed program was abandoned.

In 1947, Burns outlined a project for periodic testing of nonreactor children in an institution for the mentally ill. When children converted to tuberculin reactors they were to receive a course of streptomycin immediately. He procured a research grant from the United States Public Health Service. However, before the project was started, it was determined that streptomycin is only bacteriostatic. Moreover, it became known that in the presence of streptomycin, resistant acid-fast bacilli may emerge. Therefore, he withdrew the project.

In 1951, we began to administer anti-tuberculosis drugs to a few recent tuberculin convertors. However, as time passed it appeared that disadvantages outweighed possible advantages and the project was discontinued. When streptomycin, aminosalicylic acid and isoniazid were found to be effective in suppressing tubercle bacilli in progressive clinical disease, many physicians hoped they might sterilize lesions of primary complexes. Waring said,¹⁷ "It seems completely illogical not to treat an infectious disease at the earliest possible moment." He urged therefore, that "chemotherapy, especially including isoniazid, be used not only for the treatment of primary and minimal tuberculosis, but also as 'preventive therapy' in the treatment of certain 'convertors' of the tuberculin test from negative to positive." Waring had hoped that early continuous administration of drugs over prolonged periods might destroy all tubercle bacilli in the treated individual. Unfortunately, to date no single drug or combination of drugs has been found adequate.

It is well known that some tuberculous lesions become avascular early in their course of development. This is particularly true of those of the primary complex. Therefore, if a drug capable of killing

tubercle bacilli in the human body becomes available, we will have an opportunity for only a brief period to destroy all tubercle bacilli and thus effect cure in the strict sense of the word. Obviously, this period is between the initial invasion of tubercle bacilli and the loss of blood supply of lesions of primary complexes. Since the tuberculin tests reveals the presence of such lesions within three to seven weeks after the invasion occurs, there should still be ample time to exterminate tubercle bacilli. Such a drug is not yet known. The same facts apply to bacilli-laden, encapsulated, necrotic areas which are avascular. In human bodies exhumed for medico-legal reasons several months after embalming, viable and virulent tubercle bacilli have been recovered from avascular necrotic areas which the embalming fluid did not reach because of their avascularity.

Prevention

Immunizing agents. When our studies began, a number of so-called immunizing agents had been devised and administered. None had proved useful. The same year (1921) Albert Calmette and C. Guérin after having studied, since 1906, a bacillus originally derived from a very virulent bovine type of tubercle bacillus, were convinced that it had been so reduced in virulence that it was designated a virus fixé. Therefore, it would never regain virulence. Moreover, it would never produce tubercle formation in the bodies of people or animals. These bacteriologists were so convinced concerning these qualities and that this living bacillus had enormous immunizing powers that they gave it their names (Bacillus Calmette Guérin - BCG). B. Weill-Halle and R. Turpin¹⁸ administered BCG to infants and separated them from tuberculous members of the households. Calmette and Weill-Halle¹⁹ reported further on this work in 1926. However, the claims made for beneficial effects of BCG apparently belonged to removal of the infants from communicable cases at birth, since L. Bernard and R. Debre, France,²⁰ and A. F. Hess, Chicago,²¹ had already reported equally good results by removing infants at

birth from communicable cases of tuberculosis without the administration of BCG. Although considerable pressure was exerted by persons who accepted the recommendations of Calmette and Guérin, our group of physicians refrained. This was later regarded as an exceedingly important act when Calmette's firm belief based on faith was not supported by fact. It was found that BCG was not a virus fixé and that it not only produced tubercles but also clinical disease with some mortality.²²

In retrospect one is led to strongly suspect that it was mutation which resulted in the changes from a highly virulent bovine type of tubercle bacillus with which Calmette began in 1906 to an acid-fast bacillus which would not produce tubercles in living tissue in 1920 (BCG). Apparently, it was continued mutation from BCG which has resulted in such tremendous differences in the various cultures called BCG now extant. Some cultures have been reported to contain multiple bacterial forms which differ in size, shape, virulence, etc. Some of these cultures have killed mice on deficient diets, silicotic guinea pigs and normal golden hamsters and ground squirrels.²² Calmette was extremely insistent that no living bacillus which would cause tubercle formation be introduced into a human body. His BCG qualified. Therefore, it appears to be a misnomer to call the cultures now extant BCG which do not qualify.

The decision not to use BCG has resulted in achievement not surpassed in places where it has been used. For example, Drollet and Lowell²³ have pointed out that in the United States since 1950 the number of children born annually increased from 3,630,000 to 4,294,000. However, less than 60,000 BCG administrations were given each year (mostly hospital staff and contacts). In 1959 the tuberculosis mortality rate among children in the United States was 0.4 per 100,000. In Ontario where BCG has practically not been used the mortality rate was 0.3 in 1959.

In Quebec BCG was administered to 66,286 children in 1950 with increasing number to 142,578 in 1959. However, the tuberculosis mortality rate among the chil-

dren of Quebec was 3.7 times higher than among the children of the United States and 5 times higher than among the children of Ontario.

In France where BCG became obligatory for children and is administered to more than 500,000 annually the tuberculosis mortality rate was 1.8 per 100,000 in 1959. This is even higher than the rate in Quebec, 4½ times higher than the rate in the United States and 6 times higher than in Ontario.

The percentage of tuberculin reactors among children in the United States has been greatly reduced and thus, clinical disease among children has been correspondingly diminished. Administration of BCG carries considerable risk to the child. From various parts of the world tuberculosis lesions in children caused by BCG have been reported, not only at the site of administration but also in various internal organs and deaths from meningitis and miliary dissemination have also been reported. Recently Omodei Zorini of Rome²⁴ called attention to countries such as Scandinavia, the United States and Canada where the percentage of tuberculin reactors among children under the age of 10 years is below 5 per cent. He says, "Moreover, as Bartmann²⁵ has pointed out in such cases, the incidence of BCG complications is almost greater than the risk of contracting tuberculosis."

Drugs. Antituberculosis drugs as prophylactics are being employed in two ways, one among children who do not react to tuberculin but who may be associated with one or more communicable cases of tuberculosis. Inasmuch as some persons do not become invaded by tubercle bacilli under such circumstances it is not possible to know how effective this procedure may be. The studies of Schmidt on rhesus monkeys revealed that when those uninfected were given isoniazid and allowed to have intimate contact with monkeys which were eliminating tubercle bacilli, infections did not occur. This appeared to be good evidence that bacilli which entered the previously uninfected animals were prevented from producing lesions. For such an effect the drug must be continuously administered

throughout the period of presumed exposure.

The other condition for prophylactic use of drugs is among children under the age of three years who react to tuberculin and all others known to be recently converted. This is based on faith that if nature resorbs a capsule and liberates tubercle bacilli the drug in the blood stream will prevent them from producing endogenous reinfections.

The practicability of this procedure is seriously questioned because the acute clinical disease immediately evolves in few children and those who develop chronic lesions do so over a long period of years. Moreover, the emergence of drug resistant mutants must be considered as well as the ordeal of insuring that drugs be administered regularly for a year or more.

The number of clinical cases which develop immediately after conversion and those which evolve remotely is so small in any single year that it is more feasible to reserve drugs for clinical cases for whom their efficacy is unquestioned.

Epidemiology. It is epidemiological methods which have contributed many times more to the control and will continue to contribute many times more to the eradication of tuberculosis than all other procedures combined.²⁶ Through epidemiology, the lion's share of tuberculosis control had been accomplished before antituberculosis drugs and pulmonary resection were available. Starting the 20th century with a tuberculosis mortality rate of 311.6 per 100,000 infants, 101.8 among children of 1 to 4 years, and 36.2 for those from 5 to 14 years, the rates were decreased to 24.6, 12.3 and 5.5 respectively by 1940 and to 0.5, less than 1 and 0.37 respectively in 1961. Antituberculosis drugs were not in general use until 1947 (streptomycin) and 1952 (isoniazid). It was the finding of many persons with communicable disease by epidemiologic methods in addition to those obviously ill and providing sanatoriums for isolation plus the findings of tuberculosis in cattle and removing them which started and continued tuberculosis among children on its precipitous descent.

Eradication Goal

Although past and present procedures against tuberculosis have been extremely effective, their present usage cannot eradicate the disease. Eradication cannot be proclaimed until one generation of children after another have gone through life without having been infected with tubercle bacilli.²⁷ This accomplishment will be achieved only when all tuberculosis eradication work starts with the prenatal period. This means that obstetricians, general practitioners and health officials must arrange for a safe environment into which the infant is to be born. This can be done by administering the tuberculin test and carefully examining all adult reactors among the adults who are to be in the baby's environment. Immediately after birth, the pediatrician, general practitioner and health official should assure that the child's environment is kept free from uncontrolled communicable cases of tuberculosis. In the greater part of this country this program is well within the range of complete accomplishment.

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Is the Autopsy Out of Date?

The autopsy, once a major part of medical teaching and investigation, has fallen on hard times.

Thousands of autopsies are performed every year, but they no longer occupy the central place in medicine that they once did.

There are a number of reasons, including the development of laboratory methods for diagnosing disease, the shortage of pathologists' time, and a general shift in emphasis in medical teaching and research.

Few, if any, physicians would want to eliminate autopsies entirely, but many medical authorities are questioning the need for the number that are performed.

Is the postmortem examination thus an outworn relic from the past? No, indeed, say five pathologists and a clinician in a recent *Journal of the American Medical Association*. However, they offer several suggestions for improving the autopsy.

During life, the patient is studied with the latest, most up-to-date medical procedures, points out Joseph F. A. McManus, M.D., of the Department of Pathology, Indiana University School of Medicine, Bloomington. If the patient dies, however, the autopsy is frequently a superficial procedure that has been unchanged for a half century or more.

Two changes could improve the autopsy, points out a *Journal* editorial. The first is to restore the careful, detailed investigation that helps make it a research procedure. This may mean reducing the number of autopsies.

The second need change is to "restore the autopsy to its rightful place as a teaching instrument," the editorial said.

"Through autopsies the pathologist can answer various specific questions and provide simple 'factual' data important for the physician, the patient's family, and the statistician. For example, did the patient have peritonitis following an operation? Was a sudden death due to an embolism? Was a lung tumor primary or metastatic? Answers to such questions do not constitute 'science,' they do not advance conceptual or general knowledge, but they help the overall care of patients."

The autopsy is uniquely suited to study an individual disease, said Milton G. Bohrod, M.D., of the Department of Pathology, Rochester, N.Y., General Hospital.

"Every death corresponds to a failure, either of the individual physician, or, more commonly, of medicine as a whole. Every necropsy (autopsy) represents a last attempt to solve the enigma of the individual illness," he said.

GRAND MAL EPILEPSY ASSOCIATED WITH CHRONIC SYSTEMIC SCHISTOSOMIASIS

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WITH THE GREAT MOBILITY of today's populations, illnesses such as chronic schistosomiasis are increasingly noted in non-endemic areas. Birch and his group¹ recently reported that the increase in the number of cases of schistosomiasis in the United States has coincided with the increase in the number of Puerto Rican immigrants.

Chronic systemic schistosomiasis has remained a disease with protean manifestations.² Involvement of the central nervous system is a rare complication of human schistosomiasis.³ For the most part, some patients may present with no signs or symptoms other than a history of unexplained grand mal or Jacksonian seizures. This report presents a patient in a Chicago hospital with grand mal seizures and who was found to have chronic systemic schistosomiasis.

Case Report

A 29-year-old Puerto Rican male was admitted to the Swedish Covenant Hospital on June 14, 1964 because of unconsciousness following a grand mal seizure. Two brief episodes of transient dizziness, rolling of the eyeballs, generalized clonic convulsions and unconsciousness for about 30 minutes had occurred earlier that day. Similar episodes occurred in March and December

1963 and the patient had been taking Dilantin prescribed by a private physician.

In the Emergency Room the patient was semi-conscious with normal vital signs. Examination of the head and neck including ophthalmoscopy was negative. The heart and lungs were normal. The abdomen was soft, non-tender, and the liver and spleen were not palpable. The extremities and peripheral pulses were normal. There was no sensory or motor impairment and the deep tendon reflexes were normal. No pathological reflexes were elicited. Thirty minutes later the patient regained full consciousness. The neurological findings remained negative.

Past history revealed the patient to be an assembly worker who smoked half a pack of cigarettes daily and drank alcoholic beverages occasionally. During his childhood in Puerto Rico he had measles and chickenpox. He came to the United States in 1954 and made brief visits to Puerto Rico several times, the last in 1961. He gave no history of head trauma.

The hemogram showed a hemoglobin of 16 gm per 100 ml. and a hematocrit of 48 per cent; the white blood cells 11,800 per cmm with neutrophils 51 per cent, eosinophils 8 per cent, lymphocytes 36 per cent and monocytes 5 per cent. Urinalysis was negative. A VDRL determination was non-reactive. The fasting blood sugar was 76 mg per 100 ml. and the blood urea nitrogen 13 mg per 100 ml. The prothrombin time, alkaline phosphatase and serum glutamic

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pyruvic transaminase determinations were within normal limits. A bromsulphalein test revealed 6 per cent retention of the dye in 45 minutes. Serum electrophoresis was within normal limits except for slight A/G ratio inversion. Repeated fresh stool examinations were negative for ova and parasites. The spinal fluid revealed lymphocytes 7 per cent and neutrophils 1 per cent in the third tube; sugar was 65 mg per 100 ml., total protein 61 mg per 100 ml. and the colloidal gold determination was normal. The chest x-ray was normal. Skull x-ray showed no evidence of intra-cranial lesion, abnormal calcification or increased intra-cranial pressure. An electroencephalogram was normal.

Upon admission to the ward the patient was conscious, coherent and alert but amnesic of recent pre-convulsive and convulsive events. The physical findings remained negative. Phenobarbital and Dilantin were administered and the patient had no further convulsions during the rest of his hospital stay.

Proctoscopy revealed normal rectal mucosa. By rectal biopsy performed at the level of 8 cm from the anal orifice two specimens measuring 3 to 5 mm in diameter were obtained. The fresh unstained biopsy specimens were mashed between two glass slides and examination under a low power microscope revealed numerous *Schistosoma mansoni* ova (Figure 1). A slide with the same tissue but formalin-fixed and stained with hematoxylin and eosin was made for comparison (Figure 2). Liver biopsy with the Menghini needle showed several granulomas of the foreign-body type around *S. mansoni* ova (Figure 3). The patient was given a course of Fuadin and was discharged on long-term prophylactic anti-convulsant therapy with Dilantin. Four months after discharge from the hospital, the patient had had no further epileptic seizures.

Comment

It is apparent that this patient's exposure dated back to his childhood years although he could not remember having had the acute gastrointestinal phase of schistosomiasis.



Figure 1. Fresh unstained rectal mucosa showing lateral-spined *S. mansoni* ova (350X).

Nevertheless, the unexplained grand mal seizures considered along with the fact that this patient came from an endemic area, the eosinophilia and a negative history of trauma led us to suspect chronic systemic schistosomiasis.

Chronic systemic schistosomiasis is increasingly found in non-endemic areas, including Chicago, where a considerable number of Puerto Ricans immigrate to each year. Birch and his group¹ reported 38 patients in Chicago, all Puerto Ricans, 32 of whom were followed after lucanthone hydrochloride treatment for *Schistosoma* infestation.

The clinical picture of chronic systemic schistosomiasis is variable, and because the chronic phase of the disease may not become evident until after several years, the diagnosis is often missed. The most intriguing complication of this disease is the central nervous system involvement of which only 97 cases have been reported in the world literature.³ Marcial-Rojas and Fiol who reviewed the literature on the neurologic complications of human schistosomiasis indicated that of the 97 cases reported since 1889, 60 were due to *S. japonicum*, 11 to *S. haematobium*, and 26 to *S. mansoni*. Of the 60 cases due to *S.*



Figure 2. Formalin-fixed H & E stained specimen of rectal mucosa showing *S. mansoni* granuloma (350X).

japonicum, only 25 had definite histologic proof of the presence of schistosomal involvement of the central nervous system. The rest of the cases were diagnosed clinically on the bases of the neurological manifestations after a history of exposure to infested waters, the presence of schistosomal ova in stools, and the satisfactory response to specific anti-schistosomal therapy. The bulk of the literature in these cases was formed by the numerous reports from among American and British troops during the Second World War in the Philippine campaign. On the other hand, in Puerto Rico where 14.8 per cent of the general population is infested with the disease, only 3 cases of central nervous system involvement have been reported.

Ectopic lesions may be produced in various parts of the body outside the limits of the portal and inferior vena cava systems.¹ More recently, available evidence indicates that they are produced, in part at least, by adult schistosomes which reach these areas through arteriovenous anastomoses in the lungs and liver, or through the superior vena cava system, or through the vertebral plexus of Batson, to deposit their eggs *in situ*. Such lesions occur most fre-

quently in the central nervous system, conjunctiva, skin and lungs.

In the central nervous system the lesions are usually multiple pseudotubercles consisting of one or more eggs surrounded by giant cells, epitheloid, mononuclear and plasma cells and numerous eosinophils, or are granulomatous lesions, often containing foci of caseation.

Symptoms of central nervous system involvement may appear as early as two weeks to six weeks after the onset of illness, or they may be delayed for three or more years. The clinical syndromes include disorientation, incontinence, paralyses, unconsciousness, signs of an expanding intracranial tumor, acute or chronic myelitis, and most commonly, epilepsy.

Except for the history of grand mal seizures since one year prior to admission the clinical findings in this patient were negative. Repeated stool examinations as well as the proctoscopic findings were negative as would be expected in chronic cases. The hemogram revealed mild eosinophilia and there was slight A/G ratio inversions. Rectal biopsy revealed numerous lateral-spined ova of *S. mansoni* and liver biopsy confirmed the hepatic involvement although



Figure 3. Liver biopsy specimen with *S. mansoni* granuloma (100X).

the blood studies did not show any derangement in liver function.

The "rectoscopic biopsy by transparency" technique was devised by Ottolina⁵ who reported the method in 1947. Warner⁶ in 1956 reported this method to be about 65 per cent reliable in clinically suspected cases in his series. One of us reported⁷ 12 cases of *S. japonicum* where 11 out of that number were confirmed by this technique, giving a diagnostic reliability of 91.6 per cent. In this same report 4 out of 12 patients presented with either grand mal or Jacksonian epilepsy, indicating that involvement of the central nervous system in schistosomiasis is not as rare in the Philippines as in other endemic areas. Carter and Sheldon⁸ have also advised rectal biopsy as a reliable diagnostic method for chronic schistosomiasis.

The diagnosis is never made unless suspected and searched for by the physician. The patient's history is of great importance because exposure to and residence in an endemic area often leads to suspicion. Some patients give no history of acute symptoms and the stool findings in chronic schistosomiasis are usually negative, as are the proctoscopic findings. Rectal biopsy and examination of the fresh unstained specimen as well as liver biopsy provide convenient and reliable methods of confirming the diagnosis of chronic systemic schistosomiasis. On the bases of the history, the epileptic seizures, and the rectal and liver

biopsy findings, a diagnosis of chronic systemic schistosomiasis with central nervous system involvement was established in our patient.

The search for an effective non-toxic treatment for chronic schistosomiasis continues. Negative stools in previously positive cases do not mean the disease is gone as shown by granulomatous changes in the rectal and liver biopsies, but negative stools do indicate amelioration of the disease process.¹

Summary

A case of chronic schistosomiasis with central nervous system involvement found in a Chicago hospital is presented.

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X-RAY AND CARCINOMA OF THE ESOPHAGUS

X-ray is of invaluable assistance in the diagnosis of carcinoma of the esophagus and pharynx. The history of progressive carcinoma of the esophagus or pharynx following x-ray study by a competent radiologist, usually establishes the diagnosis of carcinoma of the esophagus or pharynx. However, as with any other laboratory tests, false positives occur and it is important to realize that the x-ray diagnosis of carcinoma of the esophagus and pharynx is not infallible. Before surgery, esophagoscopy is essential to avoid a serious error in operating for carcinoma where in essence this condition does not exist. *The Journal-Lancet*, July 1964.

NEW HORIZONS IN SCHIZOPHRENIA

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SINCE THE DAWN OF SCIENTIFIC psychotherapy schizophrenia has remained the most challenging disease entity confronting the psychiatrist. When psychoanalysis first began tackling the treatment of nervous and emotional disorders, it was felt that the schizophrenic disorders were too narcissistic or self-centered to be able to relate to the therapist in a constructive way. Electric shock and insulin therapy at one time seemed to offer promise of successfully treating many of the schizophrenic patients, but unfortunately too many other patients did not respond. More recently the tranquilizers, especially the phenothiazines, seemed to bring hope for the schizophrenic, but after an initial diminution of the population in the state hospitals, it was found that the psychiatrist was still confronted with the problem of chronic schizophrenic patients who failed to respond to any of the available modes of therapy and who would apparently require life-long institutionalization.

The prospect of life-long hospitalization is a terrible tragedy not only to the patient but also to the patient's family and friends and to society as a whole. The least important consideration is the expense either to the state or to the family. Most important is the waste of human life, which waste can be seen both from the viewpoint of the patient's individual life purposes as well as from the viewpoint of the needs of society, which the patient is now unable to fulfill. A sensitive awareness to the thwarted pur-

pose of the patient and of society can itself constitute an important new therapeutic approach for dealing with a chronic schizophrenic. From this point of view the patient is seen not as a case to be analyzed but as a person unable to relate to his world. Emphasis is not put on interpreting to the patient the structure of his thinking, which would only distress him, but rather on demonstrating to the patient that in his new world, the hospital, he can relate meaningfully and effectively. In this approach the *meanings* stressed are not those relating to intrapsychic structure but those relating to *purpose*, which brings us back to the patient's needs in the function of the hospital setting. It is in managing the encounter of the individual patient need and the therapeutic community that treatment consists. This requires that we become acutely aware of the patient's needs and the function or purpose of the hospital.*

The Outsider

The schizophrenic patient sees himself as cut off from society and indeed hopelessly cut off. He is aware of a feeling of difference from other people. He feels that he is misunderstood and that it is hopeless to even try to be understood, and therefore he cannot work effectively to make his communications comprehensible. He feels himself to be terribly alone. He is a perpetual outsider, a stranger to society. We who are

*From our point of view the very concept of the *meaning of life* is rooted in the individual's relationship to the community.

"insiders" cannot usually appreciate the degree to which accepted custom and convention make safe for us our everyday actions and our customary dealings with objects and people. If we put ourself in the position perhaps of a child going to a suddenly new situation or a primitive man being unexpectedly transported to an entirely different kind of social order, we may be able to appreciate how the schizophrenic patient is bedeviled by the impact of all kinds of new and unfamiliar situations and objects which because of their newness are terrifying. Only a gifted novelist can capture the feel of the situation, as did Joseph Conrad in depicting the horror in the descent of a lone man to an untamed savage world in *Heart of Darkness*.

A therapeutic approach which may be useful with neurotic patients will be unavailing here. To be simply impassive, to interpret neurotic distortions and transference reactions to the therapist would be fruitless. The patient is alone and cut off. He is unable in many instances to obtain even the basic gratifications which are necessary for the initial stages of personality growth. He needs to learn to feel that the world is a friendly and even loving place. This implies that he must feel that in some way he fits into the purpose of the world and similarly that the world has a place for his purposes—his needs and abilities. It can be said that what he needs is something like a good lawgiver who rules society in such a way that it benefits the various individuals in society. At a more formative level, he needs someone who can carry on the function of a loving parent who cares for the patient, a parent who has joy in seeing that the patient attains gratification and who at the same time will protect the patient from making misdirected efforts to obtain gratification that could be destructive to himself or others.

Supplying a Mother Figure

A psychiatrist who sees the patient only once a day three or four times a week cannot hope to fulfill adequately the role of the loving person who is with the patient at

work and play, when he eats and goes to bed. To fulfill this need for the ever-present mothering figure we have set up a special program for the treatment of chronic schizophrenic patients at Forest Hospital. This program is headed by the author and includes a registered nurse, three nurses aides and a representative from the occupational therapy department of the hospital. The group of workers meets each week to discuss each patient, to exchange emotional reactions to the patient, to discuss the difficulties of the patient in achieving gratification and self development and to offer suggestions as to the best approach available to enable the patient to encounter life more fully. By using an approach involving several workers who are with the patient from the time he gets up in the morning until he goes to bed at night, we are able to give the patient a feeling that he is not alone. The group of workers are not simply passive observers but rather active participants in the patient's daily life. In some instances we have fed patients by hand. Some patients are given individual baths by an aide. Patients are often taken out for excursions with various members of the staff either to eat, to go shopping, or to go to a movie. These experiences may seem to be trifling from the usual adult point of view, but it should be remembered that the patient needs "something extra" in order to feel that the world (in this case the hospital staff) really cares about him and wants him to be gratified. A shopping trip with a patient can indicate that the therapist feels that the patient is important enough to warrant an act of interest in seeing that the patient develops a positive self image through dressing properly and attractively. Eating with the patient can help him realize the possibility of mutuality in satisfaction in that the patient and the therapist are both achieving gratification together. The importance here can be seen reflected in the function of the common family meal as well as in more ancient days the importance of the communal festival and at present in the role of holy communion in the religious community.

Break Down to Rebuild

Much of the work with these patients often involves dealing with regressive and primitive needs. The group meeting of the staff workers serves almost as a form of group psychotherapy, enabling the workers to deal with the regressive needs of the patient which would often repulse the "normal" members of our society. In the process of the resocialization of the schizophrenic we often approach him as "the special one," much as the newborn infant is the special one in the family who requires particular consideration and who often disrupts many of the family routines. However, by gratifying some of the regressive needs of the patient we are enabled to establish a first primitive relationship. Once we make ourselves useful to the patient we are able to give him guidance in the art of living. From our point of view, the regression of the personality can become an opportunity for new growth, since it involves the breaking down of the inadequate, pre-morbid personality structure and

thus provides a chance to begin anew, if the patient can be made to feel safe in relating to the benevolent and well-ordered world comprising the therapeutic community. This often requires a prolonged hospitalization, because the building up in the patient of an entirely new perspective of society and of himself cannot be accomplished in a short time. The program also requires that the members of the therapeutic staff themselves have an intense dedication in order to counteract the patient's feelings of futility and isolation and to communicate to the patient our conviction that he does fit into the purpose of our therapeutic efforts. It is the *intensity* of the purpose of the hospital staff which enables it to reach out and mesh with the stunted purpose of the schizophrenic. Perhaps it will not be surprising that this sense of purpose may be seen to have an almost religious flavor in that it involves an acute awareness of the need to *save* a lost individual and the central function of religion is to unite the individual to the common purposes of the community.

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THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

This 29-year-old male entered the hospital with chief complaints of weight loss and a lump in the left side of the neck which had grown over the last year.

Physical examination revealed a well-nourished patient with a fixed, stony, hard mass in the left side of the neck which compressed the trachea to the right. The only other significant finding was enlargement of both knee joints.

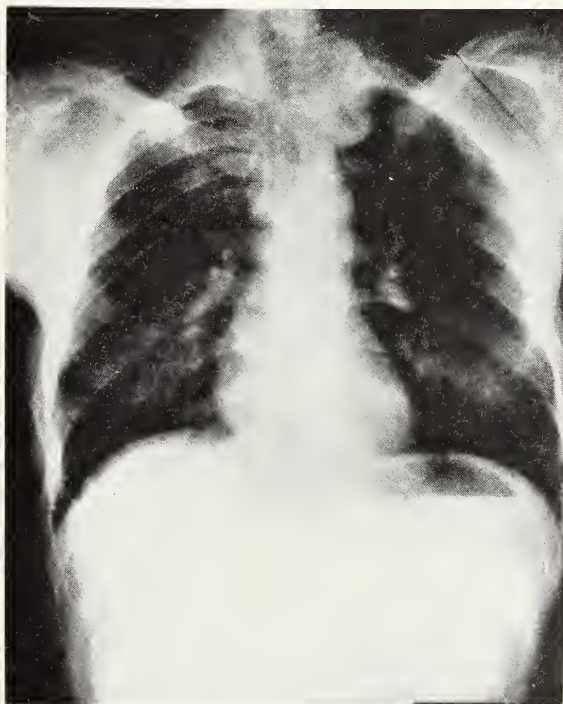


Figure 1



Figure 2

What is your diagnosis?

- 1) Carcinoma of thyroid with metastases
- 2) Hereditary multiple exostoses
- 3) Bronchogenic carcinoma, left upper lobe

(answer on
next page)

DIAGNOSIS AND DISCUSSION



Figure 3

Diagnosis: Hereditary multiple exostoses

The lesion seen to the left of the trachea is an exostoses growing from the 1st rib. Note the osteochondromata in the right humerus, one of which is seen on end. (Not to be confused with a cyst.) The large bones are the most frequent location, but the flat bone of the pelvis, scapula, ribs and vertebrae are sometimes involved. These exostoses are disturbances in endochondral growth of bones. In the long bones the exostoses usually appear at the end of greatest growth (Figure 3), at the knee when they involve the femur or tibia and at the shoulder and wrist when they arise from the humerus or ulna. At the same time as there is growth of the exostoses there is a failure of modeling of the

involved metaphyses so that it remains wider than normal. There is frequently incomplete length growth of the radius and fibula; these bones are thus shorter than their paired ulna and tibia with resultant characteristic curving at the elbow and knee. There may also be pressure deformity with erosion of adjacent bone.

The condition is familial. The trait is usually passed to the children by the father. This patient had a father and an uncle with similar findings.

In about 5% of cases there is malignant degeneration of the cartilaginous cap into chondrosarcoma in any one of the involved sites.

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A POTENT AND NONADDICTIVE analgesic having minimal side actions is of particular value to the orthopedic surgeon. The possibility of addiction carries a special threat in the treatment of chronic diseases. The physician dare not lose sight of the caution that a narcotic should never be administered when another medicament will accomplish the same purpose.¹ In addition, the preferred analgetic agent should, of course, have an early onset and long-lasting effect.

There is ample opportunity for investigating analgetic drugs in an orthopedic practice connected with a private hospital to which a large number of industrial cases are admitted. After evaluating a new analgetic combination* for more than a year, our impression was that it produced highly satisfactory results. To substantiate this general appraisal we carefully reviewed our case material. This report is based on records from our everyday intake of orthopedic patients without any explicit design for a clinical trial.

Material and Method

An unselected series of 75 patients, both ambulatory and hospitalized, was used as a representative sample for the study. There were 48 men and 27 women, ranging in age from 15 to 85 years. Many different orthopedic conditions were included; these can be roughly grouped into four classifications: strains, sprains, and contusions (22); surgical cases, fractures, and miscellaneous injuries (30); arthritis (11); other inflammatory conditions (12).

Medication was administered at a dosage of one tablet four times daily, except for three patients who received two tablets four times a day. Treatment periods varied from one day to over one year, in the majority of cases ranging from two days to three weeks. In hospitalized patients, observations were made several times a day;

*Norgesic—Riker Laboratories, Northridge, California. Each tablet contains orphenadrine citrate 25 mg., aspirin 325 mg., phenacetin 162 mg., caffeine 30 mg.

MANAGEMENT OF PAIN IN ACUTE AND CHRONIC ORTHOPEDIC CONDITIONS

James E. Segraves, M.D.,

Edward Katz, M.D. and

James J. Callahan, M.D./chicago

ambulatory patients reported at regular office visits.

Results were rated "Satisfactory" or "Unsatisfactory." Clinical response was considered satisfactory if there was complete or marked relief of pain with no side effects and if previous need for narcotics had been eliminated or greatly reduced.

Results

The clinical results are summarized in Table 1. Response was deemed satisfactory in 55 patients (73%), unsatisfactory in 20.

In the group with strains, sprains, and contusions—complaints related largely to the sacroiliac and lumbosacral regions—14 of the 22 patients responded favorably. In several instances, relief was dramatic. Particularly noteworthy was the immediate action of the drug in a 30-year-old diabetic who had suffered a contusion of soft tissue of the back. This patient had previously

TABLE 1
CLINICAL RESULTS

Diagnosis	No. of Cases	Unsatisfactory		Satisfactory	
		No.	%	No.	%
Strains, sprains, contusions	22	8	36	14	64
Surgical cases, fractures, miscellaneous injuries	30	4	13	26	87
Arthritis	11	3	27	8	73
Other inflammatory conditions	12	5	42	7	58
Totals	75	20	27	55	73

been treated unsuccessfully with muscle relaxants, codeine, and other modalities. The orphenadrine citrate-APC combination brought relief in less than 30 minutes. Five patients in this group reported side effects: four, nausea (one with vomiting); one, diarrhea. Because of nausea and vomiting one patient had discontinued medication after two weeks, but this agent was tried again five months later and it was tolerated well and the outcome was satisfactory.

The best results were observed in the second group, which included surgical cases, mostly routine surgery such as excision of knee cartilage; closed reduction of fractures; dislocations; and various types of musculoskeletal injuries, including whiplash and herniated lumbar disc. Only four of the 30 patients in this category did not respond satisfactorily. Two were middle-aged women whose severe symptoms following earlier extensive surgery could not be controlled even with codeine. These were the only patients in the group who experienced side effects: one, nausea and vomiting; the other, nausea, headache, chills, and frequent urination. Two other patients required supplementary narcotics, but at a greatly reduced dosage. Relief of pain usually occurred within one hour and lasted an average of seven to eight hours.

Among the 11 patients in the third group, presenting various types of arthritis, pain was effectively alleviated in eight (73%).

In many cases relief occurred within 30 minutes to two hours. Some patients, who responded more slowly, showed the most gratifying end results in the entire series. One, a 58-year-old man with destructive arthritis of both hips, suffered very severe pain, previously not relieved by any medication. During a follow-up period of seven and a half months the orphenadrine citrate-APC combination still afforded satisfactory relief of pain. Similar results were obtained in arthritis of the sacroiliac joint, generalized osteoarthritis, and gouty arthritis. One patient complained of dizziness, but in those requiring prolonged treatment no side actions were reported.

In the last group were patients with inflammatory conditions such as myositis, fibrotendinitis, synovitis, and bursitis. The intense pain associated with such conditions was effectively controlled in 7 out of 12 patients. No side actions occurred.

Comment

The danger of overtreatment is a recognized problem in managing pain.² For this reason alone our success with this nonaddictive agent in relieving the pain consequent to minor operations and miscellaneous injuries is significant. It suggests that a routine prescription of narcotics for post-operative pain is often unnecessary. Equally important in this context is the high rate of success achieved in our trial in various types of arthritis.

Aspirin is generally accepted as the analgesic of choice in the treatment of the arthritides³ in spite of the fact that it has been found to be effective in only 51 to 58 percent of such cases.⁴ The alleviation of arthritic pain in 73 percent of our series is better than can be expected solely with salicylates. Other investigators, too, have found that the orphenadrine-APC combination is superior to APC alone in patients with chronic pain due to arthritis and other conditions.⁵ It is evident that orphenadrine citrate* potentiates the analgetic action of

*Norflex, Riker Laboratories, Northridge, California.

aspirin and phenacetin without interfering with their antipyretic and anti-inflammatory effects.⁶

Our experience has shown that a new drug cannot be properly evaluated until sufficient time has elapsed to test its clinical worth. The promising results of our first year's trials with this new analgesic as described in this review of a small sample, has encouraged us to administer this drug routinely for relief of pain in patients with arthritic disease.

Summary

A clinical trial in 75 patients with various orthopedic conditions showed Norgesic®, a non-narcotic analgesic, to be highly effective. Side actions were minimal. The excellent results following routine operations and in patients with fractures and miscellaneous injuries indicate that this

agent can often be used successfully in preference to narcotics. Relief of pain in patients with arthritis was noted at a gratifyingly high rate (73%)—substantially better than that achieved with aspirin alone.

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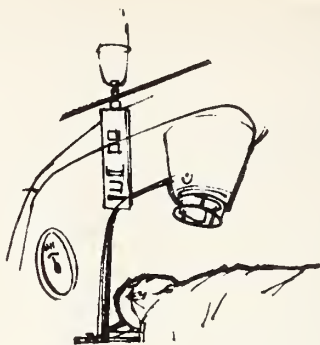
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ANTIBIOTIC PROPHYLAXIS OF BACTERIAL ENDOCARDITIS

Twenty-five to 30% of patients with bacterial endocarditis still die from their infection or complications of their disease despite the progress of antibiotic therapy during the past two decades. Probably the chief reasons for this are late diagnosis of bacterial endocarditis, late adequate therapy and failure to employ bactericidal antibiotic regimens. A contributing factor to this mortality is the failure in many instances to utilize adequate antibiotic prophylaxis in patients with heart murmurs and heart disease who undergo instrumental diagnostic procedures; minor or major operations, particularly cardiovascular bypass operations; and dental extractions.

The prophylaxis of bacterial endocarditis has been stressed in recent literature and consists of (1) adequate antibiotic treatment and prevention of streptococcal infection and rheumatic fever, the precursors of rheumatic heart disease, (2) eradication of focuses of infection in patients with valvular heart disease and (3) appropriate preoperative and postoperative antibiotic therapy in persons with heart murmurs. *The Journal-Lancet*, September 1965.

Medical Progress



HARVEY KRAVITZ M.D./progress editor

ADVANCES IN OTOLOGY

David F. Austin, M.D./chicago

PROGRESS IN THE FIELD OF OTOLOGY has been so rapid in the past decade that even full-time practitioners of this specialty have difficulty keeping pace with the many developments, both diagnostic and therapeutic. Diagnostic technics have evolved which allow accurate location of lesions involving the auditory and vestibular senses while technical advances in surgery have permitted attack on diseases previously thought to be untreatable by these means. During this same period improvements in hearing aids and teaching methods of the deaf have greatly advanced, providing help for the majority of those so handicapped.

Diagnostic Methods

The Nobel prize winner in Medicine in 1961, Georg Von Bekesey, developed one of the most important tools used in the localization of lesions of the hearing apparatus,

the Bekesy audiometer. This instrument is so designed that the patient takes his own audiogram by operating a switch which varies the loudness of the tones. A pen automatically records the values of these tones at the threshold of hearing. Two tests are done to compare the variation between the responses to interrupted tones and to continuous tones. Various patterns emerge which when correlated with the results of conventional air and bone audiograms as well as speech testing, make it possible to differentiate the exact location of the disease process affecting hearing.

More recently an equally accurate means of testing the vestibular mechanism has come into use. Electronystagmography makes use of the bioelectric potential between the retina and cornea of the eye, to record nystagmus produced by caloric stimulation of the semicircular canals. By

comparing the difference in response between the ears and the difference in response using hot and cold stimulation it is usually possible to accurately determine if the disease is located in the end organ or its central connections.

The use of these above two methods has been responsible for the early recognition of diseases causing nerve type hearing loss in their early stages and has enabled treatment to become much more specific. Their main value has been to enable the early diagnosis of acoustic neurinoma which may then be treated by otologic approaches with greatly reduced morbidity and mortality.

Neuro-otology

As improved diagnostic tools became available new surgical approaches to the inner ear were developed which have caused a rebirth of interest in neuro-otology. The most significant developments have been due to the efforts of William House of Los Angeles who has worked out two approaches to the internal auditory canal.

The middle cranial fossa approach is performed through a small craniotomy similar to that made to approach the Gasserian ganglion for tic douloureux. The internal auditory canal is opened from its superior aspect after elevating the dura from this surface of the temporal bone, thus achieving the benefits of an extradural operation. Because this procedure does not necessitate opening the labyrinth, small acoustic neurinomas may be removed or the vestibular portion of the VIII nerve sectioned without damage to the hearing function. Although this operation is technically difficult and time consuming, morbidity is practically nil with an average hospital stay of five days.

The translabyrinthine approach to the internal auditory canal enables the removal of larger tumors of the internal auditory canal. Since the approach is posterior through the vestibular labyrinth, hearing is lost, but most acoustic tumors may be removed through this approach without sacrifice of the facial nerve and with

avoidance of the morbidity associated with the classic suboccipital approach to the cerebello-pontine angle. More than seventy acoustic neurinomas have been treated by this approach with a mortality of less than 5% demonstrating the value of this procedure.

House has also revived interest in this country in the conservative surgical treatment of Meniere's disease by decompression of the endolymphatic system. This approach, originally pioneered by George Portmann of France, exposes the endolymphatic sac and drains it into the subarachnoid space. Portmann achieved this through a simple incision while House and Austin have used plastic drains. The procedure necessitates only a limited simple mastoidectomy and has been very effective in controlling the endolymphatic hydrops characteristic of Meniere's disease, achieving symptomatic relief in 85% of the cases. A very worthwhile bonus has been marked hearing improvement occurring in 25% of these patients. This development has been heartening since the use of ultrasound in Meniere's disease has shown inconsistent and often temporary relief of symptoms.

Tympanoplasty

The reconstruction of sound conduction in surgery of chronic ear disease became an important consideration fifteen years ago due to the efforts of Wullstein and Zollner of Germany. The efforts of many surgeons during succeeding years has resulted in our present ability to achieve good hearing as well as control of disease in 70 to 90% of these patients.

The former use of skin grafts to create an ear drum has now been replaced by the use of connective tissue grafts (usually vein or temporalis fascia) which are successful in 95% to 98% of the cases. These grafts are usually placed under the remaining drum margins with normal squamous epithelium regenerating across the graft from these remnants. In this way a drum of normal contour and histology is obtained resulting in good acoustic properties.

Restoration of sound conduction formerly

consisted of applying a graft to the remaining stapes if possible, while today most operations attempt to reconstruct an ossicular chain by either repositioning remaining ossicular structures or by the use of artificial prostheses. By these technics not only do more patients benefit, but the hearing result is better because of higher efficiency of this type of sound conduction mechanism.

During the time these tympanoplastic technics were developing, the mastoid operations which help control the disease process were being modified. Ways of avoiding the creation of a mastoid cavity as well as obliterative technics utilizing temporal muscle were developed. These methods resulted in the ability to preserve or recreate a normal ear canal and middle ear thus avoiding the many complications and after-care necessary in the days of radical mastoidectomy.

Stapes Surgery

Since stapes surgery became the treatment of choice in otosclerosis, progress in this field has been one of evolution spurred by an occasional mild revolution. Fifteen years ago stapes mobilization was described by Rosen and was refined eight years ago when Shea described the stapedectomy operation. This operation in essence removes the stapes completely; seals the footplate with either a natural or artificial material; and then replaces the stapes with a prosthesis—usually wire or plastic. These procedures were successful in 85 to 90% of patients in restoring full efficiency of hearing. Unfortunately, 2 to 4% of patients lost severe amounts of hearing following this procedure.

Two years ago, Shea again described a new procedure—the piston operation—in which only a small opening is made through the footplate of the stapes and a small cylindrical prosthesis placed through this opening. The success rate in this operation is slightly better, and the complication of hearing loss is reduced to one in 200 cases. Because of this marked improvement many surgeons are now utilizing this technic in the surgery of otosclerosis.

Properly timed treatment in Bell's Palsy has been a chronic problem until recent years. Recently developed methods of electrodiagnosis coupled with large statistical studies, particularly in European centers, has largely removed the question as to when to elect surgical decompression of the facial nerve in this condition.

Nerve excitability testing and electromyography is instituted on the onset of facial paralysis and repeated daily. When these tests indicate complete loss of function (which may occur as early as the fourth day after onset) surgical decompression should be performed. Approximately 95% of patients exhibiting mild or partial loss of function will recover spontaneously without surgery, but those cases allowed to progress to complete degeneration will never recover completely. Early decompression in these cases will prevent degeneration in at least 75% with full recovery of function.

The surgical technics utilized have been well known for many years, but the indications for their use have in the past been completely empiric. With the definition of these indications now clear, it only remains to educate those seeing patients with these problems to early and widespread utilization of electrodiagnosis.

Conclusion

Although, as evident in this report, great strides have been made in the surgical treatment of hearing loss there are many patients who can not at this time be helped. There are also many problems remaining to be solved. Of particular importance in this regard is disease and malfunction of the Eustachian tube which not only may cause chronic ear infection but makes its surgery more difficult. To help eliminate this problem much research is in progress introducing new technics and medications. Cryosurgery, electrode implantation, dimethylsulfoxide and other recently proposed advances are all being studied at this time. If the achievements of the past few years are any sign, the coming years will see even greater progress perhaps resulting

in the elimination of hearing loss as a major human disability.

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CHILD ABUSE REPORTS IN ILLINOIS

Meeting on December 13, 1964 the Child Health Committee of the Illinois State Medical Society unanimously recommended that ISMS support the bill on the Physically Abused Child. The Committee strongly urged the Board of Trustees to accept its judgment and actively support passage of this Bill. The Bill was subsequently signed into law and became effective on July 1, 1965. Since that date, reports of child abuse received by the State Department of Children and Family Services have averaged at least one a day.

Beating is the most common type of abuse, according to a statistical breakdown of the first 68 cases reported to the Department. After beatings there were 11 fractures, six cases of malnutrition, four burns, plus stabbings, molestations, neglect and failure to administer proper medication. Thirty-nine of the victims were two years old or under.

The Department Director, Dr. Donald Brieland, feels that the new law is very effective. "The willingness of physicians to report is especially gratifying," he said. (Doctors reported 11 of the cited 68 cases; hospitals reported 55. Under the new law both are exempt from liability arising from their reports.)

Of the 68 cases, 40 occurred in Cook County and the rest were scattered throughout the state, with one in Springfield.

Although four of the abused children died, the Department states that, for the

present, there is no evidence that the deaths were caused by abuse.

The Department's principal function is investigation of the reported cases by child welfare workers. Families involved are counseled by the workers who try to stabilize them so children can remain in their own homes. In intractable cases, the children are removed and placed in foster homes, as was the situation in eight of the 68 reported cases; immediate action was taken to prevent further harm to the children. Another 19 were serious enough to warrant a thorough investigation before the children could be returned to their homes.

Besides investigation and counseling, the Department is also undertaking a study to determine the number of children in a home where one has been abused, which information will enable the case workers to prevent abuse of the other siblings. Since it was shown that parents, either one or both, were responsible for most of the incidents, Department personnel are authorized by the Child Abuse Law to advise whether parents should be prosecuted, although the final decision to prosecute rests with the state's attorney.

The Department of Children and Family Services is maintaining a permanent central registry of all its cases and it is felt that a study of this record at some future time will yield an understanding of the roles played by circumstances and environment in the abuse of children.

ADENOCARCINOMA

OF THE APPENDIX

*Isa Sejdinaj, M.D., Richard C. Powers, M.D.,
and Charles H. Carroll, M.D./Elgin*

CONSIDERING THE FREQUENCY of disease of the appendix, it is interesting to note that there are so few reported cases of adenocarcinoma of the appendix. A review of the reported cases was provided by Tarasidis, Goodall and Farringer in 1962,¹ and the addition of their two cases brought the total number of reported cases to 66. We recently operated upon a patient whose ultimate diagnosis was adenocarcinoma of the appendix and we feel the rarity of the disease justifies a case report. There are certain problems inherent in proving the origin of an appendiceal adenocarcinoma, because of the location adjacent to the cecum. Previous reporters¹ have been careful to exclude cases in which there was a doubt as to origin; our case conforms to the criteria established for acceptance as having had definite appendiceal origin.

Case Report

History: A 37-year-old white woman was first seen November 23, 1962, with a two-day history of lower abdominal cramping pain. The pain was of intermittent character and was only mild to moderate in intensity. There was associated nausea, without vomiting. The patient had continued to eat for the first two days of her

illness, but food intake had been somewhat limited. She had a fever of 101 degrees one day after onset and said she felt feverish on the day of initial examination. She had experienced the passage of several loose stools, without showing any free blood. The patient had a previous history of intermittent episodes of right sided abdominal pain of four years' duration, this pain having been evaluated repeatedly by urologists, gynecologists, and suitable x-ray studies. No specific pathology had ever been found in the genito-urinary or gastro-intestinal tracts. At the present time the patient had no dysuria, frequency or hematuria. Her menstrual cycle had not been unusual and she was due for menses in approximately one week. The patient had been known to her physician for several years and she had a long history of a variety of neurotic complaints. She had purportedly suffered from asthma for many years, but previous pulmonary function studies had shown only minimal functional loss. She had surgery for cleft palate while still a baby.

Physical examination: The patient's temperature was 101 degrees. Blood pressure, pulse, and respiratory rate were all in a normal range. She appeared only mildly ill and seemed relatively comfortable. She evidenced no pallor or icterus. There was a well healed palatal and lip scar. The remainder of general physical examination was negative, with the exception of the

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Elgin, Illinois.

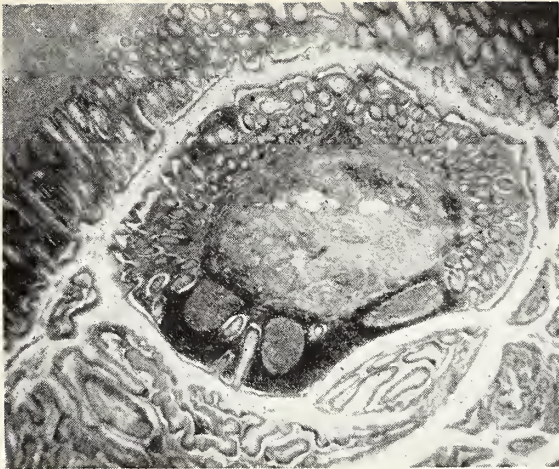


Figure 1: A bulky, polypoid tumor occupies the central lumen of the appendix. Note the glandular, frond-like character.

abdomen. The abdomen was not distended and there were no scars. Bowel sounds were somewhat hyperactive. There was generalized abdominal tenderness, but this was distinctly increased on the right side, somewhat below McBurney's point. There was no involuntary guarding. Pelvic and rectal examinations revealed only right sided tenderness, without mass formation. The extremities were normal.

Laboratory and X-ray Findings: Chest x-ray confirmed early emphysema, probably secondary to asthma. Plain abdominal films were negative. Sedimentation rate was 36 mms. in 60 minutes. Hemoglobin was 11.7 grams, and the red blood count was 3,580,000. White blood count was 17,100, with 82 segmented cells and 2 stab cells. Urinalysis was negative.

Hospital Course: The initial impression was that in all likelihood the patient had an early acute appendicitis, but it was elected to observe to confirm the diagnosis. She improved rapidly in a matter of hours, however, so conservative medical management and observation were continued. She was without symptoms, except for residual right lower quadrant tenderness, for the next four days, at which time she developed recurrent pain, fever, and elevation of white blood count. In association, a small right lower quadrant mass slowly became palpable. Laparotomy was done on November 27 with the findings of an acute, phlegmonous

appendicitis. The appendix was adherent to the posterior parietes at the pelvic brim by considerable inflammatory reaction. Recovery was rapid and uneventful. On microscopic section, the pathologist observed the classical findings of acute appendicitis. In addition, he observed a co-existing adenocarcinoma in the distal one-third of the appendix. A microscopic photograph of the primary lesion is seen in Figure 1. The bulk of the tumor occupies the lumen of the appendix. In Figure 2, the glandular and invasive character of the tumor, lying adjacent to the acute inflammatory process, is apparent.

Second Admission: The patient was electively readmitted on January 9 one month after her appendectomy. Bowel preparation had been carried out as an outpatient. The history and physical findings were unchanged from the previous admission, with the exception of a recently healed right lower quadrant scar. The patient had been asymptomatic in the interval of time. On January 10, right hemicolectomy was done, with ileotransverse colostomy, at a single stage. Her recovery was uneventful, and she was discharged on January 20. Multiple sections of the pathologic specimen showed no residual tumor in the lymphatics of the cecum or in the lymph nodes removed with the surgical specimen. The patient has been without symptoms or positive

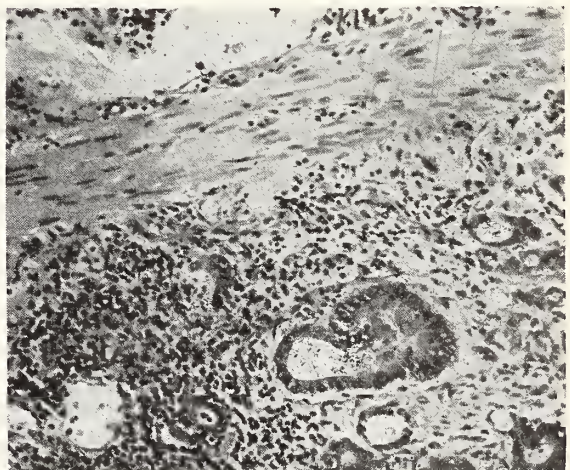


Figure 2. In an area outside the lumen is an area of infiltrative tumor.

physical findings since discharge at that time.

Comment

The addition of this case to the tabulated cases of Tarasidis, et al, brings to 67 the number of reported cases in the literature. This patient had a clear-cut case of acute appendicitis and it was secondary symptomatology that led to appendectomy. Whether the inflammatory process preceded or succeeded the neoplastic process cannot be stated unequivocally. Previous opinion has been that in these cases the tumor probably initiates the inflammatory process and this seems most likely in the present instance. In any event, the diagnosis could not otherwise be made until advanced pathology had produced a mass of sufficient size to be palpable.

In the present case, the definite presence of lymphatic invasion adjacent to the line of resection through the meso-appendix left no doubt as to the necessity for hemicolectomy. A report² by Niceberg, Feldman, and Mandelberg, described 26 cases treated by appendectomy only. Of these, seven died of proved metastatic carcinoma within five years. To treat this lesion by local operation thus is not justified, and wide resection should give a high percentage of cure. Because of tumefaction induced in an appendix which is acutely inflamed, it

seems unlikely that neoplasm will be suspected in any future cases. This lesion will continue to be discovered accidentally. Even if identified at the time of appendectomy, wide resection of an unprepared colon might prove inadvisable. While it is difficult to explain the presence of co-existing acute appendicitis and malignant tumor to the patient, the low risk of wide resection and excellent chance for cure demand that the patient understand the need for a secondary operative procedure. It would seem that if such a procedure is followed, the likelihood of a high cure rate would be great.

Summary

A review of the more recent literature summarizing reported cases of adenocarcinoma of the appendix is carried out. A report is made of a surgical case involving treatment of coincidental acute appendicitis and adenocarcinoma of the appendix. Suitable comments are made regarding the relationship existing between the present reported case and cases reported elsewhere previously. Suggestions are made regarding the treatment.

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THE CHANGING PICTURE OF TUBERCULOSIS

Consider the significant tool we have in chemotherapy for tuberculosis. With proper antibacterial therapy and surgery, when indicated, recovery can be anticipated, among cooperative patients, in well over 90 per cent of newly discovered, previously untreated cases, but such a splendid recovery rate can be attained only if the physician treating the case is skilled and experienced in the therapy of tuberculosis, and if the patient cooperates fully in his treatment. The high percentage of patients who require readmission to our tuberculosis hospitals is a dismal indictment of our inability to bring the disease under effective control during the first admission—and keep it under control. *Diseases of the Chest*, April 1965.

DURING THE PAST 16 YEARS, 24 children with leukemia have been under the care of the pediatricians at Carle Clinic. Investigative work now being conducted in the various research centers gives great promise that the day will soon come when the miracle drug will be available that will produce a cure, not just a remission of this malady.

Present knowledge gives support to various theories as to the cause of this disease. The most plausible theory now is that it is a viral infection. Ellerman and Bang in 1908¹ noted leukemia in fowl caused by a virus, and in 1951, Gross² reported cell-free transmission of mouse leukemia. It has been noted that a long period of latency may elapse between the time of the transmission of the virus in animals until there is clinical manifestation of the disease. The transfer of leukemic viruses in animals has been for the most part to animals of the same species.

Another popular concept of the etiology of leukemia is that it is due to an abnormality of chromosome 21. This theory is supported by the high incidence of leukemia in mongoloids, by the demonstration of a defect of chromosome 21 in patients with chronic granulocytic leukemia,³ and the finding of a deficiency of this chromosome in a family where two members developed chronic lymphocytic leukemia.⁴

Ionizing radiation as a factor in the cause of leukemia has been suspected for many years. In 1930, leukemia was induced in mice by irradiation and studies of the survivors of the atomic bomb revealed an increase in the rate of leukemia in humans, proportionate to the radiation dose.⁵

As a variety of agents, in addition to radiation, are known to produce chromosomal abnormalities, it may be that these induced changes in the chromosome create a fertile field for a virus or some other agent to cause leukemia.

Diagnosis

The diagnosis of leukemia in the majority of the patients in the series studied presented no great difficulty. Symptoms were

fever, general malaise, lethargy, anemia, petechiae, splenomegaly, lymphadenopathy, and an abnormal white blood count. A few patients, however, had symptoms that did not follow the classic pattern. One child had an unexplained anemia for several weeks before repeated bone marrow studies established the diagnosis. Another had symptoms that were thought to be due to rheumatic fever and was treated with steroids. This caused considerable confusion and delay in the diagnosis. One little girl was seen by her family physician because of leg ache. An x-ray taken of the knee revealed a suspicious bone lesion that led to an early diagnosis. Another child with an exudative tonsillitis and cervical adenitis was given antibiotics for several weeks before a blood count revealed the true identity of the malady.

Treatment

Although treatment of leukemia is still far from satisfactory, some rather dramatic advances in therapy have been made since Farber, et al.⁶ demonstrated in 1948 that antifolic acid compounds could produce a significant number of remissions. With these compounds and the help of others, we have been able to greatly prolong the life of the children with leukemia and while in a remission the patients have been able

LEUKEMIA IN CHILDREN

Richard E. Dukes, M.D./urbana

Department of Pediatrics, Carle Clinic and Carle Memorial Hospital, Urbana, Illinois.

to live a relatively normal life. During the period of treatment, the parents of the patients seem to adjust to the situation and are better prepared for the inevitable outcome which has not been changed in spite of advances in therapy.

As the life of these patients has been prolonged, the neurological complications have occurred with increasing frequency. Parents should be warned of the likelihood of this happening during treatment.

The drugs used were methotrexate, prednisone, 6-mercaptopurine (purinethol), vincristine sulfate (oncovin), vinblastine sulfate (velban), and cyclophosphamide (cytoxan). These drugs have been used in combination and in different sequences; the sequential use of the various medications being generally accepted as the preferred method of administration. In our experience, the exception to this has been with the use of steroids. Frequently, some form of steroid must be given along with the other agent if a satisfactory remission is to be maintained. Survival rates of over five years are now reported.⁷ These reports are encouraging and justify the institution of vigorous treatment even though in only a few patients are such gratifying results obtained. Other medications are being evaluated constantly at the various research centers and as their effectiveness is established will be available for general use.

In the treatment of the 24 children with leukemia, the ages have varied from 9 months to 13 years, 15 being under 5 years. Very little success in prolonging the life of these patients was realized until 1956, even though aminopterin was used in 1948 and cortisone in 1950. From 1948 until 1956, the average survival time of the patients, after the diagnosis of leukemia was made, was a little less than two months. Since 1956, the 14 patients treated have lived an average of 12 months. This includes one patient, a mongol, who received no specific therapy. In this series, there were patients who survived for 33, 22, 20 and 19 months. The best prognosis can be given the patient who has either a normal number of leukocytes or a leukopenia at the time of diag-

nosis. However, the child who lived the longest of the patients studied had an initial white blood count of 41,000.

Individualizing Therapy

It is advisable to individualize the therapy for each patient. In general, however, the following procedure is carried out. If the child is not critically ill, he is started on 6-mercaptopurine 2.5 mg/kg/day. Within two to three weeks the peripheral blood smear will be essentially normal if a remission is to be obtained. When control is lost with 6-mercaptopurine, methotrexate 0.2 mg/kg/day is used and following this, vincristine sulfate 0.075 mg/kg is given intravenously at weekly intervals. A very disturbing complication of the vincristine sulfate therapy has been that patients start to lose their hair after a few weeks' treatment. Supportive treatment is administered along with the specific therapy. This includes transfusions, when the hemoglobin is low, antibiotics for acute bacterial infections and gamma globulin.

If the patient is critically ill or severely anemic on admission to the hospital, he is immediately started on transfusions and given prednisone 2.5 mg/kg/day. Within a few days, when he is improved, either 6-mercaptopurine or methotrexate is given in addition to prednisone. The prednisone is gradually withdrawn over an interval of two to three weeks. It should be re-emphasized that many patients need small doses of prednisone in addition to their other therapy in order to maintain a satisfactory remission.

With one exception, all of the patients with a long survival time developed central nervous system symptoms and were given intrathecal methotrexate. This is given in amounts of 0.3 mg/kg/dose on every 3rd to 5th day until the spinal fluid is normal. Three administrations are usually sufficient to accomplish this and the remission will last from one to 20 months.

Other drugs used have been cyclophosphamide and vinblastine sulfate. Their effectiveness is not impressive and as they are

very toxic agents, as are the other drugs, they must be used with extreme caution.

These children usually die of massive hemorrhage or septicemia. One of the patients of this series died while his leukemia was apparently under excellent control; he had been exposed to rubeola and during the incubation period he developed a fulminating pneumonia and died. Autopsy revealed a severe giant cell pneumonia.

Conclusion

Investigators appear to be on the threshold of establishing the cause of leukemia. With a better understanding of the etiology, rapid advances in therapy should be forthcoming and a cure for this fatal disease may be available in the not too distant future. Meanwhile, it behooves all physicians to use all the therapeutic tools at their disposal

to control the disease in their patients, hoping that the breakthrough in therapy will come in time for them to benefit from it.

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ILLINOIS TO STUDY ROLE OF THE NURSE

Illinois has joined a number of other states in beginning study of the dependent and independent functions of nurses. Representatives of the Illinois State Medical Society and the Illinois Nurses Association have met for the purpose of developing a statement to guide individual practitioners and health agencies as to the role and responsibility of the doctor and the nurse in carrying out certain procedures.

Joint statements to guide decision-making groups in hospitals and health agencies is expected. The statements may cover the following areas:

Recommendations that hospitals and agencies in the state set up patient care committees of physicians, nurses and administrators to determine the role and responsibility of the doctor, the nurse and the employing agency in the performance of certain procedures; closed chest cardiac resuscitation; administration of investigational drugs; and administration of anesthesia during labor.

Because of widely differing situations, the statements are expected to be very general, mainly emphasizing the need for individual hospitals and health care agencies to develop their own guides delineating responsibilities.

COMMUNITY HEALTH WEEK—

PAST AND PRESENT

Four years ago, Community Health Week was just an experimental "pilot" program in St. Clair County, Illinois.

The idea was to make the public aware of the total health services and facilities available in their communities, emphasizing local responsibilities in planning for future community health needs.

No wonder that Matthew B. Eisele, M.D., East St. Louis, is a little amazed by it all. For today, Community Health Week (November 7-13, this year) is not only state-wide; it has become a national observance.

And Dr. Eisele started it all, in 1962. Four years later, he still heads an Illinois State Medical Society committee in charge of Community Health Week.

In fact, so successful was the program in 1962 that the next year it was adapted by the American Medical Association House of Delegates as a nation-wide observance.

Community Health Week has had encouraging as well as significant results:

This year, in Illinois alone, for example: a \$50,000 promotional campaign was launched, including contributions from the Chicago and Illinois Heart Associations; full-page CHW advertisements in 20 of the state's largest dailies by Illinois Bell Telephone; an advertisement by Hertz Rent-All; radio and television spots featuring Johnny Morris of the Chicago Bears and Ernie Banks of the Chicago Cubs, honorary co-chairmen of Community Health Week.

Last year, new events and new methods of informing the public about health facilities included hundreds of well-planned efforts:

In Michigan: Open House in hospitals, rehabilitation institutions, nursing homes and other medical facilities, with special emphasis on physical therapy and careers involving rehabilitation.

In New Mexico: A youth press conference for 24 journalism students from Albuquerque high schools, with the best story produced by the students published on the front page of a local newspaper.

In Colorado: A 30-minute TV "newsreel" film developed by the Denver Medical Society describing roles and functions of the health team.

In Florida: A 16-page Sunday newspaper supplement devoted to the growth and availability of medical services in Palm Beach County.

And so on across the nation. But the beginnings were not so auspicious.

"We recognized that many people had a distorted or partial view of the total health services and facilities available to them in their communities," Dr. Eisele said. "And we were cognizant of the need to emphasize local responsibility in planning for future community needs.

"So our sub-committee set to work to develop a broad community health program that could serve as a blueprint for other medical societies to follow," he concluded.

And a blueprint is just what his sub-committee provided.

In that first observance—under the auspices of the Illinois State Medical Society—a prototype for other societies was established. For one thing, the St. Clair

County experiment demonstrated the wide range of activities which can be centered around Community Health Week to spark the enthusiasm and interest of every individual in the community.

Here is a sampling of results from that 1962 beginning: St. Clair County's week-long observance included a three-day health fair with 40 exhibits, films and lectures (and a surprise visit by motion picture actress Janet Leigh who awarded special prizes to school poster and slogan contests); Community Health Sunday observance in churches; TV and radio appearances by physicians; seat-belt installations in automobiles; tours of hospitals (including lectures on cancer); speeches before civic and women's groups; and wide "press," including articles and editorials endorsing Community Health Week objectives.

In 1963 the program was established on an annual, national basis by resolution of the AMA House of Delegates at its Los Angeles meeting and the first nationwide observance was scheduled for October 20-26.

The AMA sent Community Health Week kits to state societies and the Illinois State Medical Society designed its own kit to assist county societies in planning the week-long campaign.

In 1964—as an example of how the effort has grown and progressed—ISMS enlisted the aid of former St. Louis Cardinal baseball star Stan Musial as chairman.

"Stan the Man was the ideal public figure to personalize our 1964 theme of physical fitness, not only as one of the all-time baseball greats, but because he was also the director of the President's Council on Physical Fitness," Dr. Eisele said.

Musial did not just "lend his name." He posed for publicity photographs, helped prepare news releases and editorials and recorded radio interviews.

Other 1964 ISMS promotions included: distribution of 2,500 pamphlet racks to pharmacists throughout the state; binding of a pliable plastic phonograph record into the *Illinois Medical Journal*; with an appeal by Musial to physicians to join in Com-

munity Health Week observances; and the distribution of five recorded messages to Illinois radio stations.

Community Health Week, 1965, was held to be the biggest promotion yet in Illinois, according to Dr. Eisele.

Sports figures Banks and Morris, as honorary co-chairmen, made radio and television appearances to ask the public to "go to bat" and "get on the ball" for the voluntary health agencies.

In addition to the items mentioned previously, a special, three-part series was distributed to 90 Illinois dailies, with a feature story especially written for the 610 weeklies. A suggested editorial was sent to both weeklies and dailies.

Radio and television spots were prepared; Morris and Banks were honored at a special half-time program during the Bears-Baltimore Colts football game on November 7 in Wrigley Field before some 40,000 people, where Lieutenant Governor Samuel Shapiro presented them with special plaques.

The Chicago Medical Society published 50,000 copies of a directory of Illinois Voluntary Health Agencies for distribution to physicians, county medical secretaries and to fill individual requests; in addition ISMS produced a special five-minute "Medical Interview" with Louis de Boer, executive director of the Chicago Heart Association for broadcast over 50 Illinois radio stations.

"The sky's the limit with almost infinite possibilities," Dr. Eisele said, regarding Community Health Week. "It opens to citizens a rare opportunity to visualize the health team as a whole, to see and learn of its present and past progress and to gain, through personal observation and participation, a greater appreciation and understanding of the cooperative, community-wide effort required to safeguard and advance health.

"It is our responsibility to see that Community Health Week continues to progress—that health facilities and the need for local community planning for the future are recognized, understood and acted upon," Dr. Eisele concluded.

EDITORIALS

CORONARY THROMBOSIS

A low fat diet may help to lower the plasma cholesterol level and affect the age of onset of coronary disease, but it is of no value after myocardial infarction has occurred. A research committee¹ from the Central Middlesex Hospital in London went a step further and found that the low fat diet did not alter the relapse rate.

They came to this conclusion after conducting a controlled trial of a low fat diet on 264 men recovering from a first myocardial infarction. They were divided into two groups; one was placed on a 40 gm. fat diet while the other remained on their normal diets. The overweight individuals, regardless of group, were given reducing diets. Three dietitians were available to offer advice on eating. The trial ran from 1957 to 1963.

There was no doubt that the low fat diet lowered the serum cholesterol level (average 263 to 223 at the end of two years). A slight but not significant drop occurred among the controlled. The others lost weight, more so on the low fat than on the usual low caloric diet. The relapse rate after four years was 38 per cent among the low fat group and 40 per cent of the control group.

A report from Norway² clarifies the role of saturated fats in the mechanism of atherosclerosis and linolenic acid in the prevention of coronary thrombosis. Many factors, including elevated blood pressure, lack of exercise, cigarette smoking, obesity, stress and elevation of serum cholesterol contribute to the thickening of the arterial wall. The occlusion that develops in the artery is regarded as a complication caused by an internal hemorrhage or an increased adhesion-aggregation of the blood platelets. The latter increases the tendency to thrombosis. Owren of Oslo presents evidence that this takes place when rats are fed a saturated fat diet that is deficient in linolenic acid. For contrast, the increased aggregation tendency of the platelets can be reduced to normal by ingestion of linolenic acid. This is administered in the form of refined linseed oil. Owren suspects that the increased tendency to thrombosis in certain population groups is related to a relative deficiency of linolenic acid.

Theodore R. Van Dellen, M.D.

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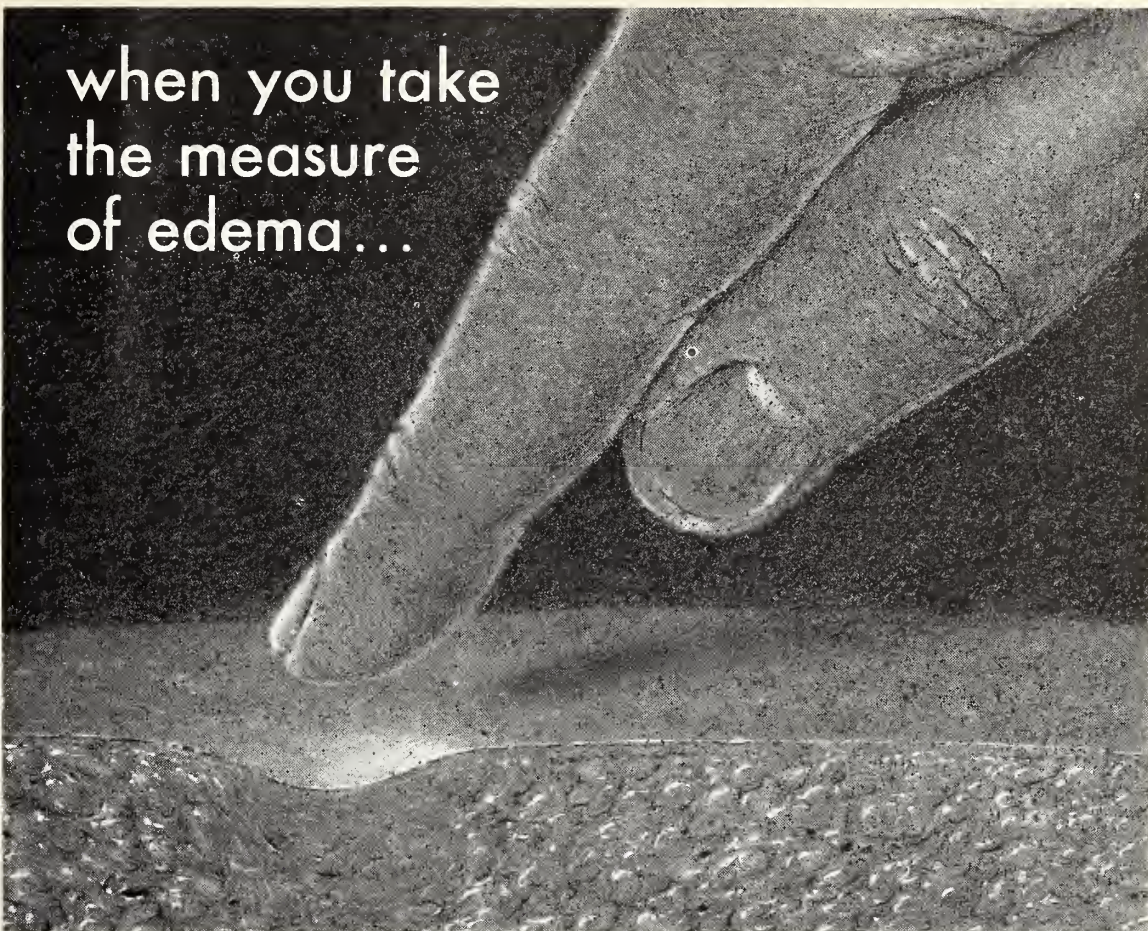
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DISABILITY EVALUATION

The evaluation of permanent disability must be carried out with a working knowledge of the Illinois Workmen's Compensation

Act. In this presentation, the salient features of this Act, as pertaining to physicians, will be discussed. If one thinks

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PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting,

diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

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of the definition of disability as referring to alteration of body structures resulting in a lessening of ability to perform established physical accomplishments, the basic problem of evaluating disability from the viewpoint of Workmen's Compensation will be better understood by the physician. More simply stated, the Illinois Workmen's Compensation Act attempts to not only compensate the worker for permanent alterations to his body physiology or structure, but it also compensates him for the effect of these alterations on functioning in his particular job or occupation.

Certain basic definitions must be understood:

(1) *Temporary total disability or incapacity* means the complete inability to work for a temporary time. In general, the number of weeks of temporary total disability has no relationship to the number of weeks provided in the eventual estimate of permanent disability.

(2) *Permanent disability* is that disability of the body, or one or more of its members, after recovery has reached its maximum. This disability is usually referred to as *partial*. It may, however, be *total*.

(3) *Specific losses* refer to permanent disability in which there is a specific loss of a member, such as amputation of a finger, hand, arm, toe, foot, leg or losses to vision or hearing.

(4) *Non-specific losses* refer, usually, to situations where there has not been specific loss of a member of the body, but where there is permanent injury causing diminution of function and, by the same token, inability to perform established physical capabilities.

Permanent partial disability is expressed in terms of weeks. In the case of specific losses, the site of amputation can easily be expressed by the examining physician so that the insurance claims-man or attorney should be able easily to assess the number of weeks of permanent partial disability. In the case of non-specific losses, evaluation of permanent partial disability becomes

much more difficult. The physician is frequently at a loss to evaluate permanent partial disability in terms of percentages of a finger, hand or arm in the upper extremity; or in terms of toe, foot or leg in the lower extremities. Many formulas have been developed for this by physicians writing on the problem of disability evaluation. These formulas usually involve the loss of joint motion, loss of motor power, neurological deficits and many other defects; these formulas are cumbersome, complicated and frequently approach the ridiculous. It probably would be easier for the examining physician to express loss in terms of *small*, *moderate* or *major* in the use of function of a member, e.g., finger, hand, arm, toe, foot or leg.

Evaluation of disability arising from back injuries affords probably the greatest problem in the evaluation of permanent disability. A review of the Illinois Workmen's Compensation Act discloses that other than a compression fracture of one or more vertebral bodies, no mention is made of evaluation of the usual problem of low back pain arising from sprain, aggravation of pre-existing degenerative arthritis or the herniated disc. In general, evaluation of disability arising from back injuries is expressed in terms of percentages of one or both legs. Here again, however, the physician need not necessarily give percentages of loss. He should, ideally, express himself in terms of the effect of the patient's back injury on function of the lower extremities and on his ability to perform established physical skills.

The physician involved in examining a patient for evaluation of permanent disability is required to give only objective physical findings, normal and abnormal. Subjective findings are, by law, not permissible. At the conclusion of any report, the physician should summarize his findings in a manner that will be understandable to a layman conversant with the problem of disability evaluation.

Henry W. Apfelbach, M. D.



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Meeting Memos



November 19-22—"Impact for Tomorrow" is the theme of the 1965 annual convention of the National Society for Crippled Children and Adults (The Easter Seal Society) to be held at the Palmer House, Chicago.

Kenneth K. King, Denver, Colo., convention chairman and trustee of the National Society, announced that a feature of the four-day meeting will be a communications institute on "How To Listen," conducted by Ralph Nichols, Ph.D., professor of rhetoric at the University of Minnesota and a national authority in the field of communications.

A National Exposition of Arts and Crafts will be another highlight of the convention. This project is co-sponsored by the Women's Committee, President's Committee on the Employment of the Handicapped and the National Society.

Leaders in the rehabilitation field will participate in general sessions, seminars, workshops and institutes presenting new techniques and methods in the care and treatment of crippled children and adults.

The Chicago Easter Seal Society, an affiliate of the National Society, will hold its annual meeting in conjunction with the convention.

November 22—The latest clinical and research information on Hodgkin's Disease will be presented at a Symposium, co-sponsored by the American Cancer Society and the National Cancer Institute at the New York Hilton Hotel, New York City. All interested physicians, medical students and investigators are invited to attend this program which will emphasize the clinical management of Hodgkin's Disease. There is no advance registration or registration fee. For further information write Jack W. Milder, M. D., Research Department, American Cancer Society, Inc., 219 East 42nd Street, New York, New York 10017.

... continued on page 555

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Dosage

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Contraindications, Precautions, Adverse Reactions

No specific contraindications are known. Since large doses can produce peripheral vasodilation, the drug should be used cautiously in patients with hypotension and in acute myocardial infarction when the blood pressure may be labile. Headache, dizziness, nausea, flushing, weakness or syncope, and mild gastrointestinal distress have been reported.

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Warning: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

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Meeting Memos . . .

continued from page 550

November 24—A seminar on "Character Disorders" will be presented at the VA Hospital, Downey, Illinois, Bldg. 5, Room 204, from 10:00 a.m. to 12 noon. The speaker will be John I. Nurnberger, M. D., Professor and Chairman, Department of Psychiatry, Indiana University Medical Center, Indianapolis.

December 1—The expanding role of the dentist in the early detection of oral cancer with emphasis on the latest diagnostic developments and research is the theme of a Symposium on Oral Cancer co-sponsored by the Chicago Unit of the American Cancer Society and the Chicago Dental Society, to be held in the Sheraton-Blackstone Hotel, Chicago, from 9:00 a.m. to 4:30 p.m.

Participating in the program are Chicago area dentists and doctors prominent in the field of cancer control who will present papers on the prevalence of oral cancer, examination procedures, the etiology of total management of the oral cancer patient, techniques in the early detection of oral cancer and progress in the metropolitan Chicago oral cancer detection program of the Chicago Board of Health.

More information is available from the American Cancer Society, Illinois Division, Inc., 37 South Wabash Avenue, Chicago 60603.

December 11—The Illinois Registry of Anatomic Pathology will hold the first of its semi-annual seminars at 1:00 p.m. in the auditorium of the Hektoen Institute for Medical Research. "Hepatic Pathology" will be the subject presented by Hans Popper, M.D., Dean, Mt. Sinai Medical School; Professor and Chairman of the Department of Pathology, Mt. Sinai Hospital, New York.

Subscribers to the Registry will receive slides and transactions and may bring their residents to the seminar. Non-subscribers may participate for a fee of \$20.00 payable to the Illinois Registry of Anatomic Pathology. Apply to Paul B. Szanto, M.D., Registrar, Hektoen Institute, 627 South Wood Street, Chicago.



MANAGEMENT OF COMPLICATIONS IN EYE SURGERY.

Edited by R. M. Fasanella, M.D. Second edition. 543 pages, illustrated. \$18.50. Philadelphia. W. B. Saunders Company. 1965.

The first edition of this book appeared eight years ago and received a warm reception. Rather than discussing only the complications of ocular surgery, the editor stressed the indications and techniques of surgery which would best keep these unpleasant occurrences to a minimum.

This positive approach has been maintained in this enlarged second edition. One hundred pages and a large number of illustrations have been added. Also added are a table of drug reactions, a section on cardiac arrest, and two new chapters—one on cryosurgery and a second on photocoagulation.

This is a careful revision of a useful text. It is recommended to both the apprentice and the mature ophthalmic surgeon. David Shoch, M.D.

MANAGEMENT OF THE PATIENT WITH SUBNORMAL VISION. G. Fonda, C. V. Mosby Co., St. Louis; 161 pgs., price \$11.00.

Management of patients with subnormal vision has always been a most perplexing and in many cases discouraging problem for ophthalmologists. In addition to this, it is frequently difficult to decide what to do for a patient with subnormal vision. The literature has been rather scant in the coverage of this problem. Therefore, Dr. Fonda's book is a most welcome addition to the ophthalmic literature.

The book is well illustrated, emphasizing optical aids, telescopic systems, methods of measuring visual acuity in handicapped patients, Braille, and some techniques in examining patients whose vision is abnormal. Anyone who treats visual problems should get this book which is the best that I've seen on this subject.

Thomas Chalkley, M.D.

OPHTHALMOLOGY: PRINCIPLES AND CONCEPTS. Frank W. Newell, M.D. 491 pages, 172 illustrations. \$12.25. St. Louis, The C. V. Mosby Company, 1965.

This reviewer is at an advantage. He has just had several medical students on his hospital service who used this book for reference reading. These were all seniors who elected a clerkship in ophthalmology and who had used another standard

text during their junior year didactic course in this subject, so that they had some basis for comparison. Their comments were uniformly enthusiastic and centered around several things. First of all they felt that the introductory summaries to each chapter were a great help in orienting them to the subject under discussion. Secondly they stated that the material was presented in a form that tied it in more closely with knowledge they already possessed so that they did not feel lost in a mass of specialized terms. Thirdly they thought the illustrations clear and excellent. Being at this point interested in clinical medicine, they made particular mention of the chapter on pharmacology and the section on systemic diseases and the eye.

This reviewer, some distance removed from his medical school days, agrees completely with this evaluation. In addition he was pleased to find a brief but adequate discussion of retinal chemistry and visual mechanisms and in the clinical section a sensible, practical approach to diseases such as uveitis about which little is known.

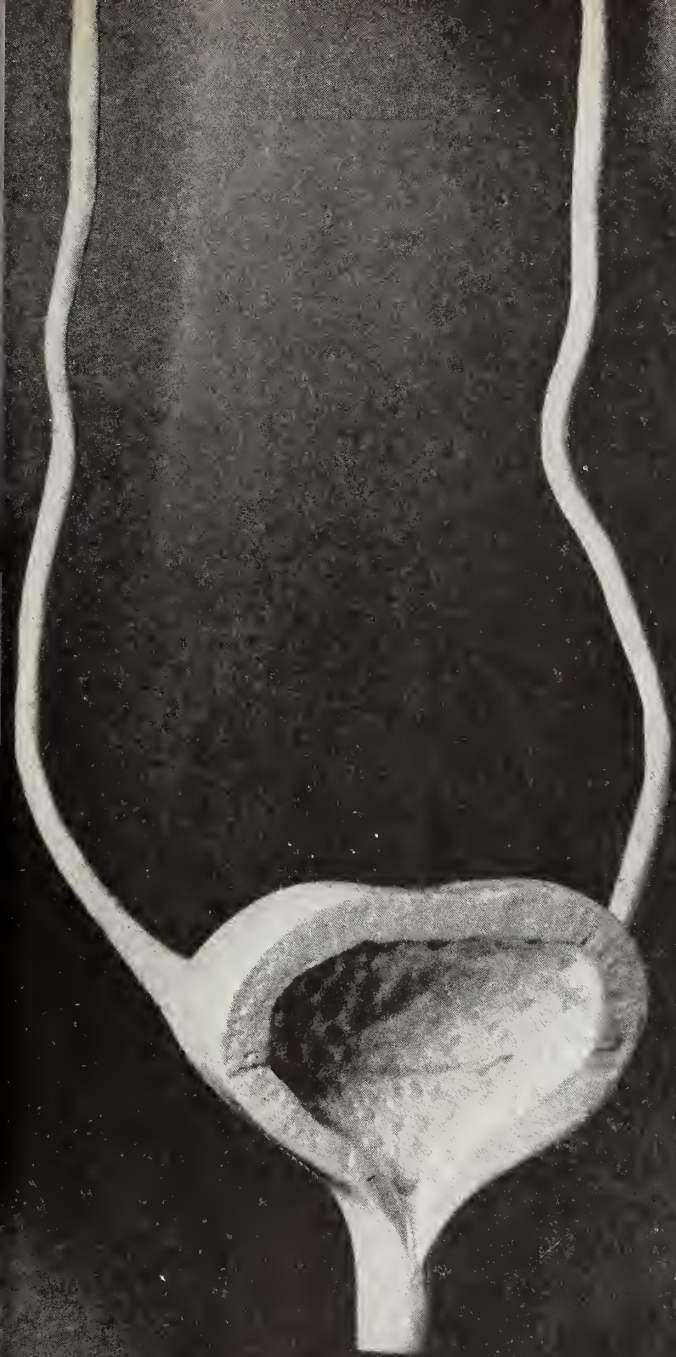
All in all, this is a most worthwhile text. It is highly recommended to medical students and general practitioners as a basic textbook of ophthalmology. In addition the resident in ophthalmology will find it an excellent review for his boards. It will help him organize the mass of detailed information he has hopefully been accumulating for some three years.

David Shoch, M.D.

METABOLISM OF LIPIDS AS RELATED TO ATHEROSCLEROSIS compiled by Fred A. Kummerow. C. C. Thomas, Springfield, Illinois, 1965. 300 pages.

This volume contains a series of papers presented at a symposium on the metabolism of lipids held at the time of the dedication of the Burnside Research Laboratory at the University of Illinois in Urbana in June, 1963. After initial introductory remarks there follow 17 scientific papers pertaining to the problems of the metabolism of lipids and their relation to various aspects of atherosclerosis. The first four of these are of general interest to almost any reader; however, the remaining papers are of chief concern to those particularly knowledgeable in the special field of lipid chemistry. Some of the material has been published elsewhere but the volume is a useful compilation for those undertaking research in this area.

Oglesby Paul, M.D.



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And while we wish, others work.

These are the dedicated people in the profession of medicine who are working to make our wish reality.

And these are also the people who give their time and effort to the volunteer health agencies in our state. People whom we salute during Community Health Week (Nov. 7-13) which originated in Illinois.

We and our children are fortunate to live in a state that is world-famed for its medical education, research and treatment; famed not only for its facilities, but for its physicians, nurses, and researchers. One out of five doctors in the United States has received all or part of his training at an Illinois medical school or hospital. Many of these, practicing right here, have pioneered work in various medical fields spanning from problems of the newborn to life in space.



For example, many Illinois physicians are pioneering the use of new diagnostic tests that can detect mental retardation in a newborn and indicate treatment that can cure it. Thousands of children, right here in Illinois, will be saved from retardation because of these tests. Thousands will be saved, too, because of new vaccines, drugs and anti-microbial agents that already have reduced the risks of whooping cough, lockjaw, diphtheria, polio, tuberculosis, and encephalitis resulting from measles.

Life in space poses a new challenge for the medical profession.

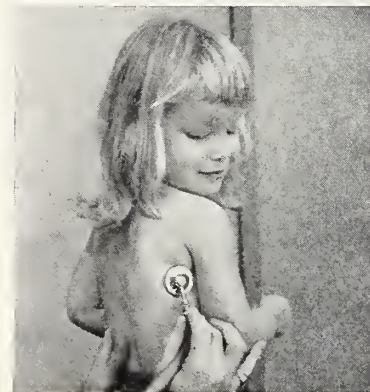
At the University of Illinois Aeromedical Laboratory, for example, our researchers are pioneering work that will safeguard the lives of our moon explorers. For the last two decades, our researchers here have been learning what happens to a man's heartbeat, circulation, respiration, eyesight, hearing, and total bodily reactions in the takeoff, flight, and landing of spacecraft. The orbital flights of our own astronauts have been made possible in part by findings from this research.

And the work continues in all phases of medicine, in all our great medical schools in Chicago; at university research facilities in Champaign-Urbana and at Carbondale; at clinics and hospitals throughout the state; and it will continue at the new mental health centers being built right now in Rockford, Chicago, Maywood, Peoria, Springfield,

Decatur and Champaign.

Our children can know good health here in Illinois...and they can help others to know it, if their talents so lead them to the profession of medicine.

They'll be able to because we are fortunate to have in this state, an enlightened and progressive partnership of government, education, business, industry, civic and reli-



gious organizations...along with the medical sciences and allied health professions...working together to provide the leadership and facilities to match our children's needs and potential.

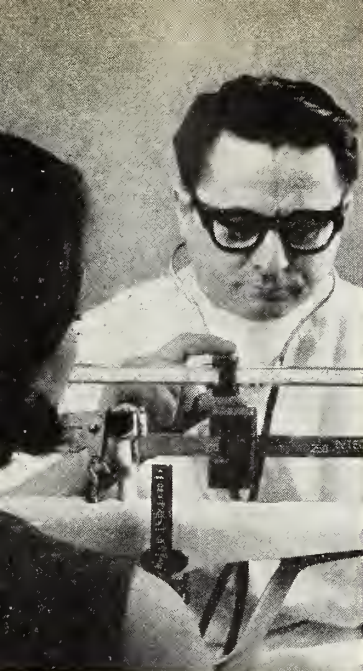
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THE TAZEWELL PROFESSIONAL SYMPOSIUM

"To render educational programs for self-improvement of our members" is one of the three aims of IMAA. This aim was put into action on Sunday, September 19 when the Tazewell County Medical Assistants Association hosted the annual professional symposium of the Illinois Medical Assistants at the Pekin Country Club in Pekin. Members from nine of the thirteen component societies attended. A total of eighty medical assistants were present for the day-long seminar.

The program began with a workshop on education, ways and means, and membership. Marilyn Knuth, education chairman for Tazewell county, was the leader, assisted by a panel consisting of the IMAA executive board. They were Shirley Kleinschmidt, president; Sue Karels, president-elect; Sandra Bredthauer, recording secretary; Luella Mitchell, corresponding secretary; Synobia Payne, treasurer; Alta Teter, second vice-president; and Corinne Berg, immediate past president. Groups discussed the way their chapters handle these problems and the panel clarified points where needed.

Jeanette McCammon, nursing director of the Peoria chapter of the American Red Cross, told of her experiences in bringing Cuban refugees to this country during July, 1963. As the result of this experience, she said she felt it was a privilege to be an American. She said that the refugees were not only low income groups, but professional people as well, as the Cuban government had confiscated the personal property of its citizens. She told of caring for the people coming here on the ship.

The afternoon session began with an excellent speech by Dr. Max Klinghoffer,

chairman of the Disaster Medical Care Committee of the Illinois State Medical Society and the Du Page County Medical Society, on "Disaster Medical Care." He described the packaged hospital which is patterned after the MASH unit of the Korean war: M—mobile; A—army; S—surgical; H—hospital. These emergency hospitals are used until such time as definitive care can be undertaken elsewhere. For additional information on the packaged hospital see the *Illinois Medical Journal*, September 1965, page 361.

The program was concluded with a talk by Mr. Loren F. Richard, representative from the Dale Carnegie Institute, on "The Human Relations Factors." He emphasized the fact that we only get out of something what we put into it—that unless we participate in the activities of an organization, we cannot expect to get anything from it. He said each of us has talents and we should use them. We should make use of what we learn at meetings, in classes, in reading, etc., or the learning is useless.

Many Illinois Medical Assistants are going to the annual convention of the American Association of Medical Assistants in New York, October 11-17. They are proud to have the opportunity to vote for Elvera Fischer, a member of the Chicago Medical Assistants Association, for president-elect of AAMA. She is a graduate of the Kahler School of Nursing, Rochester, Minn., a former airline stewardess, a charter member of AAMA, founding and charter member of IMAA, president 1957-58, founding and charter member of CMAA as well as its first president, and Illinois' first certified medical assistant, to list but a few of her activities.

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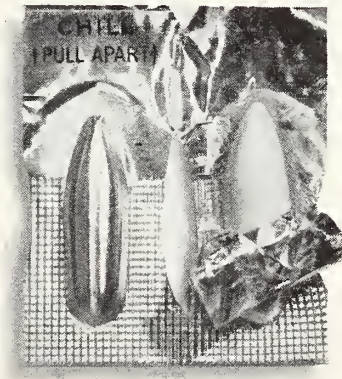
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Dr. SIMS in ACTION

ADMINISTRATIVE AND COMMITTEE ACTIVITIES
OF THE ILLINOIS STATE MEDICAL SOCIETY

November, 1965

Committee to Study Maternal and Perinatal Deaths

The Committee to Study Maternal and Perinatal Deaths of the Illinois State Medical Society met on October 20. Dr. Stuart Abel, Chairman, opened the meeting by listing the objectives of the proposed study: (a) introduction of a registry which would provide a complete record of all maternal and perinatal deaths in Illinois; (b) standardization of protocols; (c) accurate measurement of the number and causes of death; (d) utilization of results for educational purposes; (e) provision of a standard model for other states to use; (f) evaluation of obstetric and pediatric procedures; and (g) reduction of mortality on both maternal and perinatal areas.

The master plan was reviewed and the step-by-step movement of protocols and statistical summaries traced on flow charts. Considerable discussion was held on how to obtain accurate protocols from hospitals and it was agreed that in the perinatal study the hospital record librarian would be the best source. The importance of obtaining the full support of the Illinois Hospital Association was indicated.

In the case of the maternal mortality forms, Dr. John H. Rendok volunteered to get the completed forms from Cook County Hospital and the suburban Cook County and downstate hospitals. In line with this, Dr. Robert E. Lane, representing the Chicago Board of Health, offered to complete the forms for maternal deaths occurring in Chicago.

Although a budget cannot be worked out at this time, the following costs are to be included in its ultimate preparation: (a) travel expenses for all involved; (b) meal expenses for all meetings; (c) printing costs for forms; (d) part-time clerical help as may be needed; and (e) educational workshops in the field to present the findings of the surveys.

No particular leads were given as sources of funds but a preference was expressed for obtaining a grant from private sources rather than the federal government.

When the project is officially established, it was suggested that members representing the nurses and nurse anesthetists be included in the committee.

Attending the meeting were Dr. Abel, Chairman; Drs. Robert R. Hartman, Paul A. Raber, William W. Curtis, Clay Burchell, Simon Y. Saltman, Leo Perucca, John H. Rendok, D. F. Rawlings, Matthew J. Bulfin, Robert E. Lane; John A. Taft, Jr. and Isabelle Crawford.

"Joint Blood Alcohol Study" Discussed By Public Safety Committee

At its meeting on October 14, the Public Safety Committee of the Illinois State Medical Society examined HB 132G, the "Joint Blood Alcohol Study," which takes effect January 1, 1966 through December 31, 1966.

Attending the meeting were: Dr. Julius M. Kowalski, Chairman; Drs. George H. Irwin, Edwin A. Lee, Norman J. Rose, Clifford P. Sullivan, and Clarence E.



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Cawvey; Mrs. Joseph Shanks, Auxiliary; and James Thompsen, Second Vice-President, Illinois Coroner's Association.

The Bill, which provides for testing all traffic fatalities in the State of Illinois for blood alcohol and carbon monoxide, was discussed and clarified.

Dr. Rose exhibited the test slip which will be required to accompany all samples submitted to the coroner. The form consists of three copies, all to be sent to the State Laboratory; from there, one copy goes to the Coroner, one is retained by the Laboratory and the final copy is sent to the Department of Public Health Springfield office for tabulation.

A suggestion, approved by the Committee, was made to add the word "occupant" to the form, which previously listed driver/suspected driver/pedestrian.

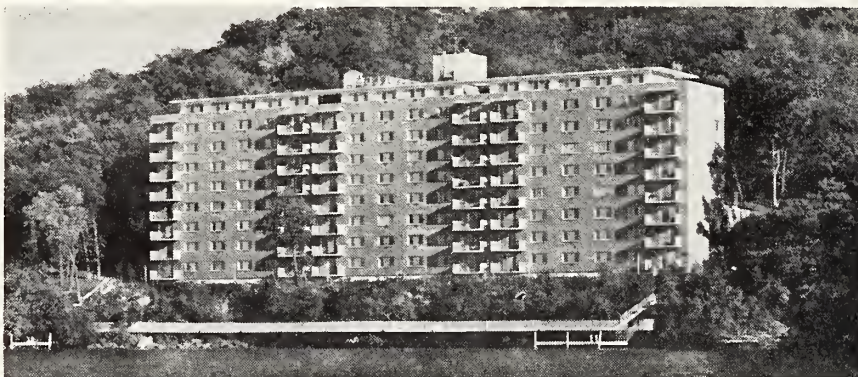
Dr. Rose asked for recommendations regarding the distribution of the blood sample tubes and pointed out that the State anticipates roughly 2000 fatalities during the period of the project. The proposal was made by Mr. Thompsen, and approved by the Committee, that tubes be sent to

Coroners who would take the responsibility for proper distribution.

It was pointed out that the medical technician in a hospital does have authority under the law to draw blood, but he would have to be notified by the Coroner's pathologists that such authority is granted. Mr. Thompsen suggested the Coroner in each county notify each hospital so it would exist as a standing order and become an automatic procedure. Dr. Rose will work with Dr. Oblinger in Springfield to work out the Coroner's pathologist authorization form to send hospital laboratories.

Dr. Rose asked the Illinois State Medical Society to request its members to draw blood wherever possible to save money. Chairman Kowalski said an *Illinois Medical Journal* article would encourage them to do this.

The Committee pointed out that physicians should realize they assume no liability in such action, as per 1961 SB 322 and HB 1362G. As they are carrying on research projects, the Illinois Department of Public Health, the Illinois State Medical Society, or any licensed hospital could not be liable for civil or criminal action.



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The Commodore

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Chairman Kowalski introduced a pamphlet, to be available with a film on the same subject, about December or January, entitled "Panic or Plan?" The pamphlet, published by Metropolitan Life with the cooperation of various medical groups, will tell how people in local hospitals handle accident cases and methods of preventing accidents.

Program for Narcotic Addiction Conference Presented to Committee on Narcotics

A program for the Illinois Conference on Narcotic Addiction was presented and discussed by the Committee on Narcotics of the Illinois State Medical Society, which met on October 15. The program was subsequently approved by the Board of Trustees on October 24.

The Conference will be scheduled for March 24 and 25, 1966 and will comprise three half-day sessions of panel discussions. On Thursday, March 25, after the Welcome by Dr. Burtis E. Montgomery, ISMS President, and Orientation by Governor Kerner, the first session will be devoted to "The Addict and the Drug" and will be moderated by Dr. James Eckerhoff. A Conference Dinner will be held that evening, with a speaker yet to be selected.

"The Addict and the Community" will be the theme of the opening session for Friday, March 25, to be moderated by Dr. J. Lindesmith. The final session of the Conference will have as its subject "The Addict and Treatment" with Dr. Stanley Youllis as moderator.

The data presented at the Conference will also be used as source material in developing an educational pamphlet planned by the committee.

Evolving from the Conference will be the creation of specialized Task Forces to work in those problem areas which will prove the most significant for Illinois. The Narcotics Committee will be instrumental in the organization and operation of the Task Forces.

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Part II, November 29
SURGERY OF COLON & RECTUM, One Week, November 15
GALLBLADDER SURGERY, Three Days, November 15
SURGERY OF HERNIA, Three Days, November 18
FRACTURES IN CHILDREN, One Week, November 15
TREATMENT OF VARICOSE VEINS, One Week, December 13
PROCTOSCOPY & SIGMOIDOSCOPY, One Week, December 13
ARTERIOGRAPHY, Four-Days, November 30
VAGINAL SURGERY, One Week, December 13
PATHOLOGY REVIEW COURSES FOR SPECIALTIES,
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ADVANCES IN CARDIOLOGY, One Week, November 15
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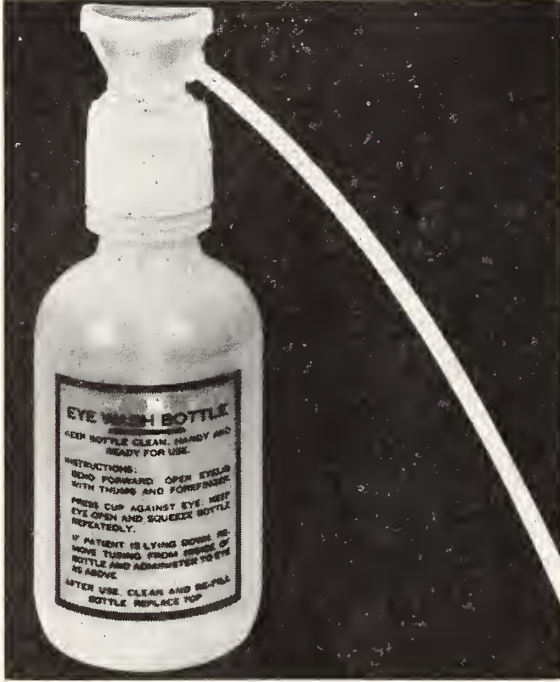
* U.S. Pat. #3150049 © 1965 by Sardeau, Inc.



Rx Reviews

and New Products

Eye Wash Bottle



A new irrigating eye wash bottle is now being distributed by General Scientific Equipment Company, 7516 Limekiln Pike, Philadelphia, Pa., and is available for the first time in two sizes (16 and 32 ounces).

These bottles are made of unbreakable Polyethylene, extremely flexible and easy to use. Simply bend over bottle, open up eye lid with thumb and index finger, press cup on top of bottle against eye and apply pressure repeatedly on bottle. Persons in prone position can use the bottle by removing the inside tube.

Doctors advocate immediate washing to remove foreign matter and to prevent serious injury. Quick, emergency action is most important. With these handy irrigating eye wash bottles, eye injuries can be treated on the spot—fast and effectively. 16 ounce capacity, \$2.50. 32 ounce capacity, \$3.00, special discounts for quantity purchases.

Four Additions to "Dac System"

Four frequently used hospital medications have been added to its "Dac System" by the William S. Merrell Co., Cincinnati, Ohio. The new additions expand the Dac System of single-dose medications to include the most frequently used narcotic and barbiturate preparations.

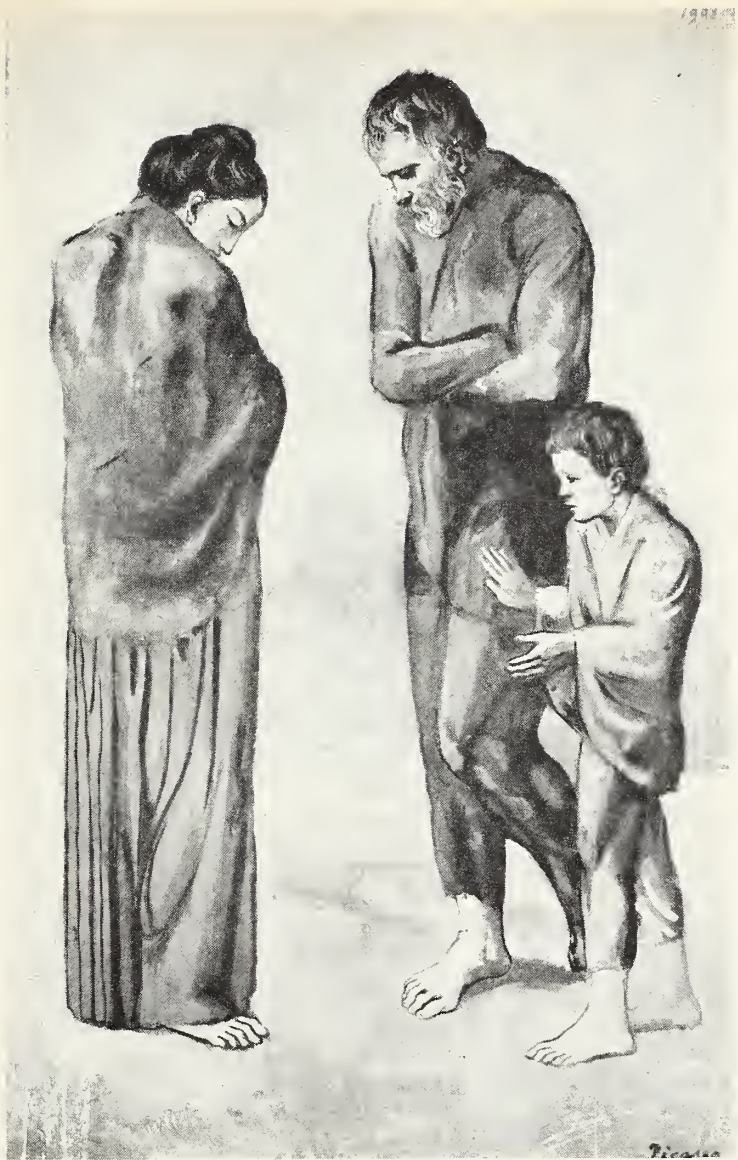
The barbiturate additions coincide with the signing into law of the amphetamine-barbiturate bill (H.R. 2) which requires more stringent control of stimulant and depressant drugs. Dac System products comply with the new regulations, facilitate inventory and control, and insure greater accuracy of medication administration.

The four additions are: 'Talseco,' sodium secobarbital capsules, U.S.P. (100 mg.); 'Talpentio,' sodium pentobarbital capsules, U.S.P. (100 mg.); 'Talamo,' sodium amobarbital capsules, U.S.P. (200 mg.); 'Tal-pheno,' phenobarbital sodium injection (120 mg. per 1 cc. ampul).

The Dac System is based on the unit-dose concept and assures positive identification of medication to the moment of patient administration. Each single-dose package is identified with the name of medication, potency, the Merrell name and quality control number.

Dac System tablets and capsules are strip-packaged in transparent or foil laminate and then placed in convenient dispensing boxes. Ten of these dispensers are arranged in a zip-open hospital pharmacy stock package. Ampuls available in the Dac System are packaged in clear plastic dispensing boxes of ten. Each ampul is always visible in the "see through" plastic box for identification and inventory check.

The Merrell Dac System for the distribution and control of medication is designed to be compatible with all hospital drug distribution procedures.



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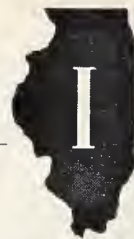
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Medical Education Anniversary Highlights Clinical Convention

The 200th anniversary of medical education in the United States is being observed in Philadelphia as the American Medical Association holds its 19th Clinical Convention there November 28-December 1.

The convention is being held in cooperation with the bicentennial observance of the nation's oldest medical school, the University of Pennsylvania School of Medicine.

Physicians and their families will be able to participate in ceremonies observing the school's founding. They also will have opportunities to visit other parts of historic Philadelphia.

Independence Hall, the Liberty Bell, Betsy Ross' house and the old Custom House are among many important historical sites that make Philadelphia one of America's most interesting cities to visit.

Philadelphia has many luxurious hotels and colorful restaurants. Blocks of rooms in ten major hotels have been reserved for those attending the convention.

For more information on registration, write to Circulation and Records Department, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

Michael Reese Dedicates New Research Center

Michael Reese Hospital and Medical Center dedicated its new \$4.2 million medical research center, the Dreyfus Research Laboratories, on Tuesday, October 12.

The gift enabling construction of the building was received from the Dreyfus family of Paris, France. Representing the donors were Mr. & Mrs. Samuel Rosenthal. Mr. Rosenthal is a prominent Chicago

attorney. The gift exceeded \$1 million. Matching funds were received from the National Institutes of Health, United States Public Health Service, and from the Medical Research Institute Council, a lay organization raising funds for research at the hospital, and other groups and individuals.

The 12-story Dreyfus Research Laboratories will more than double the available research space at Michael Reese. The building houses 12 of the 23 full-time medical research facilities, including those in cancer, cardiovascular diseases, biochemistry, microbiology, gastrointestinal diseases, surgery, allergies, pathology, thoracic medicine and physical medicine.

The Dreyfus Research Laboratories is the latest of the five buildings to be completed in the current phase of the hospital's redevelopment program. Ground was broken simultaneously in October, 1961, for the buildings which represent a total expenditure of more than \$10 million. The majority of the funds required for the construction of the buildings were received from private contributors. The balance was received from government sources.

Governor Kerner Names TB Advisory Committee

Governor Otto Kerner recently named a 16-member Tuberculosis Advisory Committee for the Illinois Department of Public Health and Hospital Licensing Committee.

"Modern day medicine has reduced the length of stay for tuberculosis patients from 18 months to nine months or less," Gov. Kerner said. "Tuberculosis at the turn of the century was the number one cause of death across the nation, whereas today it is sixteenth.

"With this progress, however, problems



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ON EMPLOYMENT OF THE HANDICAPPED**

NEWS and ANNOUNCEMENTS (cont'd)

have resulted. A recent survey of the number of patients in tuberculosis hospitals in Illinois revealed that out of about 3,000 beds, about 1,000 were empty."

The governor said there are many aspects to the problem and that he has asked the broad-based committee to do a complete study. The staff of the Department of Public Health, under the direction of Dr. Franklin Yoder, will provide the staffing for the committee.

Named to the committee were Dr. Edward A. Piszczek, Forest Park, field director of the Suburban Cook County Tuberculosis Sanitarium and chairman of the Board of Public Health Advisors for the State of Illinois; Dr. John Porterfield, Chicago, director, Joint Commission on Accreditation of Hospitals and chairman, Task Force on Tuberculosis to the Surgeon General, U.S. Public Health Service; Dr. Mark Lepper, Chicago, head of the Department of Preventive Medicine of the University of Illinois.

Dr. D. H. Trumpe, Springfield, medical director of St. John's Sanatorium and treasurer of the Illinois Tuberculosis Association; Dr. Walter Bornemeier, Chicago, director of the Tuberculosis Institute of Chicago and Cook County; Dr. W. D. Tuttle, Harrisburg, a director of the Illinois Tuberculosis Association; Dr. K. G. Bulley, Aurora, medical director of the Kane County Springbrook Sanitarium.

George K. Hendrix, Springfield, administrator of Memorial Hospital and chairman of the Hospital Licensing Board of the Department of Public Health; Ray E. Wachter, Downers Grove, president of the Illinois Tuberculosis Association; Mrs. Laura E. Lunde, Chicago, a member of the Advisory Hospital Council to the Department of Public Health; Sen. James Donnewald, Breese; Sen. Harris Fawell, Naperville; Rep. Adlai Stevenson, Chicago; Rep. Carl W. Soderstrom, Streator; Willard Bunn Jr., Springfield, and Dr. Yoder.

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MEDICAL DIRECTOR

OBITUARIES

Eli Bader*, Chicago, died October 4, aged 49. A graduate of Chicago Medical School in 1944, he specialized in psychiatry. He was a staff member of South Chicago hospital.

Edward V. Boarini*, Chicago, died July 26, aged 74. He was a graduate of the University of Illinois College of Medicine in 1934.

Henry W. Cheney*, Chicago, died February 13, aged 96. He was a graduate of Northwestern University School of Medicine in 1892. He was also an emeritus member and a member of the Fifty Year Club of ISMS.

Richard M. Davison, Chicago, died June 21, aged 60. A graduate of the University of Minnesota Medical School in 1929, he was a faculty member of Stritch School of Medicine. He was formerly secretary of the board of directors of the City of Chicago Municipal Sanitarium where he was a member of the staff.

Dominic S. Di Ciro*, Olney, died July 11, aged 71. In 1917, he was a graduate of St. Louis College of Physicians & Surgeons.

Thomas F. Forrest*, Woodstock, died September 17, aged 60. A graduate of Loyola University Medical School in 1935, he had been a staff member of Memorial hospital, McHenry County, since 1936.

Archie E. Gillis*, Chicago, died October 2, aged 69. A graduate of Rush Medical School in 1926, he was a staff member of St. Anne's hospital.

Herbert G. Hempler, Johnston City, died September 15, aged 76. A graduate of the University of Illinois College of Medicine in 1911, he practiced in Johnston City for 46 years.

Louis J. Hlavacek, Chicago, died May 12, aged 71. He was a graduate of the University of Illinois College of Medicine in 1939.

Margaret M. Jones, Chicago, died September 20, aged 89. She was a graduate of the University of Illinois College of Medicine in 1903.

Asta E. Lynn, Chicago, originally from England, died September 28, aged 76. A graduate of Chicago College of Medicine & Surgery in 1912, he was a staff member of Little Company of Mary hospital.

Stewart J. McCormick*, Chicago, died September 16, aged 62. In 1929 he was a graduate of Marquette University School of Medicine and specialized in obstetrics and gynecology. He was a staff member of Little Company of Mary and Roseland Community hospitals.

Clarence E. Merkle*, Alton, died September 3, aged 65. A graduate of Beaumont Hospital Medical College, St. Louis, in 1928, he specialized in diagnosis and internal medicine. He was former chief of staff at St. Joseph's hospital and a founder of the Alton Clinic. He was also a Fellow in the American College of Physicians.

Ernest T. Moon*, Mahomet, died September 19, aged 37. He was a graduate of the University of Illinois College of Medicine in 1955.

Ester F. Quigley*, Chicago, died June 10, aged 69. She was a graduate of Loyola University Medical School in 1918.

Lowell Sallee, Schaumburg, died September 24, aged 31. A graduate of the University of Louisville School of Medicine in 1960, he was a resident physician at the Illinois State Psychiatric Institute.

Guy E. Seymour*, Mattoon, died July 15, aged 62. He was a graduate of the University of Illinois College of Medicine in 1931.

Alexander Victor*, Chicago, died July 13, aged 61. He was a graduate of Facolta di Medicina e Chirurgia dell'Universita di Napoli, Naples, Italy, in 1929.

Francis L. Wiza*, Chicago, died April 15, aged 61. He was a graduate of Loyola University Medical School in 1928.

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Illinois Medical Journal

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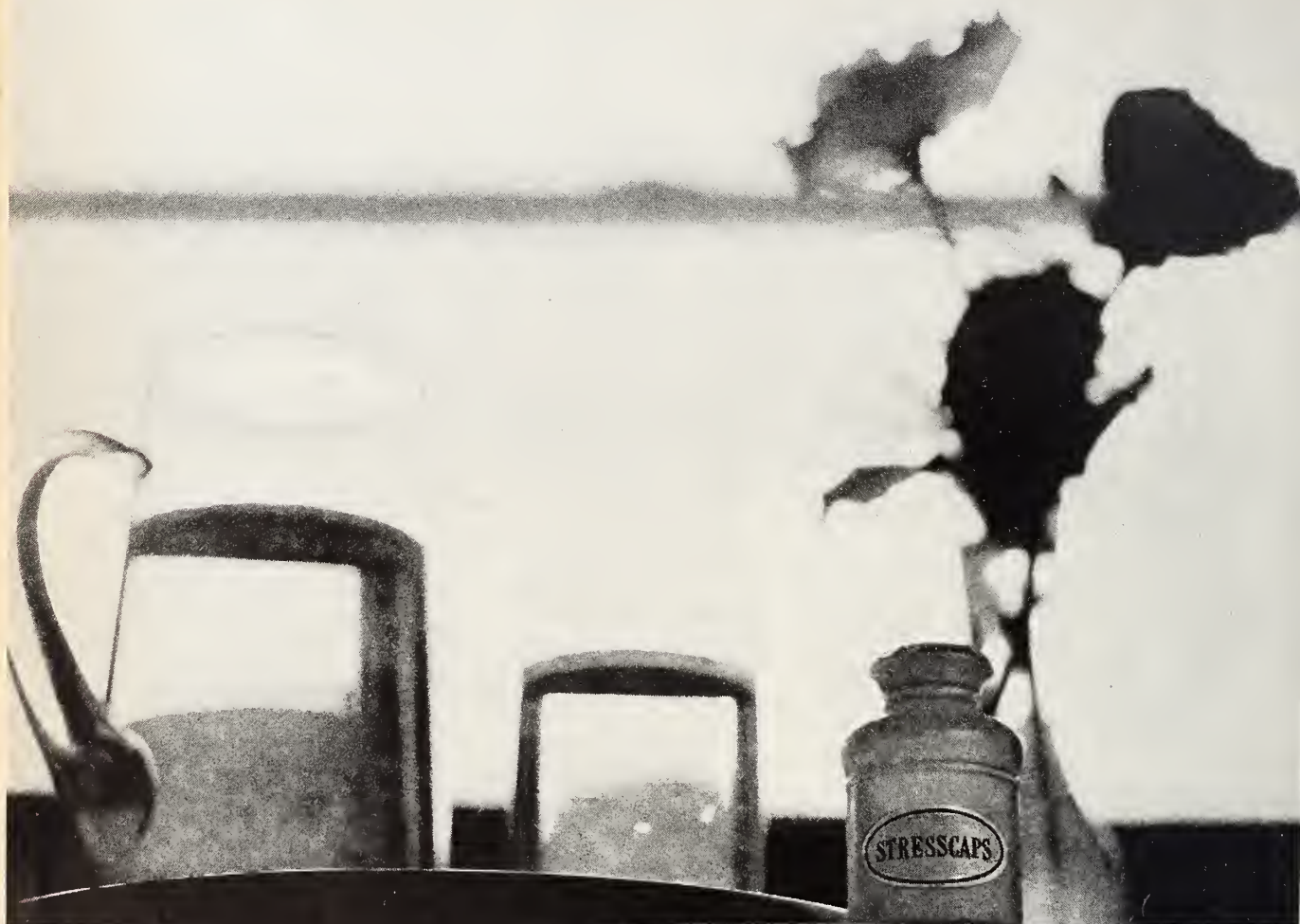
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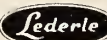


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ABSTRACTS OF BOARD ACTIONS

MEETINGS OF OCTOBER 23-24, 1965

BOARD ADOPTS EIGHT RECOMMENDATIONS ON MEDICARE POLICY

The Board of Trustees has adopted eight definite recommendations of the Legislative Committee regarding implementation of Public Law 89-97 (Medicare).

1. That an individual physician acting independently and not in concert with others, may lawfully and ethically elect to treat or not to treat persons under the Medicare program, and that medicine will oppose any program which will interfere with the physician's freedom of choice with respect to participation or the acceptance of financial arrangements under which he shall provide care.

2. That current practices and customary procedures with respect to certification of hospital admission and care should be continued under Public Law 89-97 and that hospital utilization committees should be composed of practicing physicians.

3. That the Board of Trustees appoint a three-man committee to meet with Illinois Medical Service for further details and information and with other potential carriers under P.L. 89-97.

4. That the charges for the services of hospital-based specialists should be billed and collected in the same manner as are the fees of other physicians.

5. That the ISMS membership be fully informed as to the provisions of the law and their rights regarding payment.

6. That a policy be adopted which provides that all governmental programs, federal and state, reimburse physicians according to the usual and customary fee within the community without reference to any existing payments schedule.

7. That ISMS join with the Illinois Hospital Association in establishing a coordinating committee with the key voluntary and governmental agencies most involved in Illinois.

8. That the Committee on Legislation be assigned to continue studying all facets of the administration of P. L. 89-97 and its implementation and report to the Board of Trustees at regular intervals.

COMMITTEE STRUCTURE MAY BE COMPLETELY REVAMPED

The Committee on Committees has drawn up a list of 16 recommendations for improving the ISMS committee system. Aimed at making the committee structure more effective through consolidation and the setting of general operating rules, the recommendations will continue under study until next year when they are presented to the 1966 House of Delegates.

NEW SURVEY OF MEMBERSHIP OPINION APPROVED

The Board has authorized a new survey of the Illinois State Medical Society to determine current interests and attitudes of its members. Conducted by the Opinion Research Corporation whose 1959 survey resulted in the present organization of the Society, the new study will be made in time for reporting to the 1966 House of Delegates.

PUBLIC AFFAIRS COMMITTEE BEGINS "OPERATION FIRESIDE"

The Public Affairs Circuit Rider programs have been tailored to fit into individual homes in Cook County. Known as "Operation Fireside," trial sessions have been scheduled in the homes of Dr. Philip Thomsen, Dr. Herschel Browns, and Mrs. John Van Prohaska.

PARTY TO REPLACE ANNUAL BANQUET AT CONVENTION

The Board of Trustees has approved President B. E. Montgomery's proposal to eliminate the annual banquet from the 1966 convention program and to replace it with a party, possibly using a Gas Light Era theme. The convention will be May 15-18 at the Sherman House in Chicago.

ABSTRACTS OF BOARD ACTIONS---(CONT'D)

MEETINGS OF OCTOBER 23-24, 1965

NEEDS OF ARMED FORCES THREATEN PHYSICIAN SUPPLY

The Illinois State Medical Society will take whatever steps are necessary to maintain adequate medical care in areas where physician population may be depleted by needs of the armed services. The Executive Administrator will obtain information regarding boards and commissions involved in the "clearing" of physicians for military service.

ISMS TO PUBLISH CALENDAR OF EVENTS

Lederle Laboratories has provided the financial support needed for publication of a monthly calendar of medical meetings in Illinois. Publication of "What's Going On" is expected to begin in January and information about appropriate meetings should be sent to the Society immediately.

IUCD RECOMMENDATIONS APPROVED BY BOARD

The Board of Trustees has concurred with the following recommendations of an ad hoc committee on IUCD:

That those institutions and facilities now using the intra uterine contraceptive devices be authorized to continue their use for public aid recipients; and that the Medical Director of the Illinois Department of Public Aid be empowered to authorize individual physicians to use the devices on a study and research basis.

PUBLIC AID DEPT. REQUESTS REVIEW COMMITTEES

In accordance with a request from the Illinois Department of Public Aid, the Board has authorized each trustee to appoint "review committees." Each trustee will be asked to supply the names of at least three physicians to the headquarters office for this purpose. These physicians may be members of existing district grievance committees.

SPONSORSHIP OF NARCOTICS CONFERENCE APPROVED

The Board has authorized the Committee on Narcotics and Hazardous Substances to conduct a Conference on Narcotic Addiction next spring. Co-sponsors will be the American Medical Association, Chicago Medical Society, Illinois Department of Mental Health, Chicago Department of Mental Health, U. S. Bureau of Narcotics, and the Council on the Understanding and Rehabilitation of Addicts. It is hoped that the Conference will develop a specialized task force to work on the problems of narcotics addiction.

MINUTES OF BOARD MEETINGS MAILED TO ALL DELEGATES

By official action, the Board of Trustees voted to make available to all members of the House of Delegates the complete minutes rather than a summary of its meetings on October 23-24, January 15-16, and March 12-14. After this trial period the practice will be evaluated before it is made permanent.

Policy Manual of the Illinois State Medical Society

October 1965

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House may appear as a portion of the annual report of the Policy Committee, or they may be contained in other reports

to the House. The final statements for publication in this Policy Manual are to be prepared by the Policy Committee. Any member of the Illinois State Medical Society may submit a policy statement for consideration.

Temporary policy between meetings of the House, is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois, and the Society must recognize such policy until it has been changed at the national level.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic processes.

Preface

Webster defines "policy" in various ways. Policy is "government," or the "science of government; prudence or wisdom in the management of affairs; sagacity or shrewdness." Policy is "a settled course adopted and followed by a government, institution, body or individual."

The Policy Committee of the Board of Trustees has the responsibility to maintain current policy statements, publish them annually for the use of officers, trustees, committee chairmen, members of the Society and headquarters staff and employees.

As this manual develops, cross indices will be maintained. The Policy Committee felt that no "rules and regulations" should be included; that this committee should deal in general policy statements only. The committees of the House and the Board of Trustees should prepare the rules and regulations under which they should operate, subject to annual supervision and approval by the House of Delegates.

Newton DuPuy, M.D., *Chairman*
Arthur F. Goodyear, M.D.
Frank J. Jirka, Jr., M.D.

Assessments and/or Dues

Voluntary assessments and/or contributions may be solicited from dues-exempt members of ISMS.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees of the Board. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Education

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in

the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees.

Individuals covered by various fee schedules shall receive the best type medical care in all cases, and the physicians involved shall be remunerated according to the accepted fee schedule. Fees should be commensurate with services rendered.

Financial Policies

(also see "Assessments," etc.)

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees; however, such recommendations must be approved by the Board.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice.

All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, etc., and any other area which involves the health of the residents of this State.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

Hospitals

Physicians should sponsor and assist in the development of utilization committees in all hospitals.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

Hospital Staff Privileges

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

Immunization Program

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should

properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Insurance Plans

Physicians are urged to cooperate with voluntary health insurance plans approved by the Illinois State Medical Society.

Senior citizens who are covered under these approved policies should be served at appropriate adjusted charges.

Insurance programs for the membership of the Illinois State Medical Society should be studied and implemented by the proper committee. Major medical and comprehensive hospital group coverage should be part of this insurance package.

Journal Publication

The Journal Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the Illinois Medical Journal.

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Legislative Committee for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be

checked against recommendations or policies of the American Medical Association by the Legislative Committee of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Legislative Committee, which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Legislative Committee should primarily consider relationship of the proposed legislation to the total legislative program.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

Membership in the Illinois Association of the Professions is encouraged. Medicine should be well represented among these allied professional groups and the growth and development of the Association is of concern to ISMS economically, politically and scientifically.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Mental Health

Mental health planning should be implemented at the community level. County medical societies should be kept aware of their responsibilities to assist in developing improved mental health facilities.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Occupational Health

Occupational health is an essential ingredient of

employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of all physicians involved in industrial work.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Press

All county medical societies should cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Publication (of Research Data)

In releasing research material to the press for publication in the Illinois Medical Journal, or any other media, extreme care should be exercised. The welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state society advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type of medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be checked and adjusted in a fair and equitable manner.

An extensive program of education should be conducted for the recipients of public aid. There should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Equality of payment to private physicians will serve the medical needs of recipients of public aid; should prevail throughout the State.

Residents of Illinois eligible for medical care through the State Department of Public Aid programs should have the necessary services available regardless of the county in which they reside.

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Reference Service

Physician reference service shall be the responsibility of the county medical society. When a such request is received at the state society office by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only.

A co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon the recommendation of the committee with approval of the Board of Trustees.

Upon request, copies may be furnished third party payors of health care services.

Stationery, Use of Official

No officer, trustee, committee chairman or staff member is to use the official stationery of the Illinois State Medical Society for personal statements of any kind. This shall pertain especially to the endorsement of any candidate for public office.

Endorsements

The Illinois State Medical Society endorses the

principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

Woman's Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

RESOURCES AVAILABLE FROM THE ILLINOIS DIVISION, AMERICAN CANCER SOCIETY

Under its by-laws the American Cancer Society is prohibited from owning or operating any medical facilities such as a clinic, etc. However, through the availability of certain limited funds and the activities of a very fine group of volunteer workers, it can provide certain supplies and services in many communities in Illinois. Briefly, it promotes locally certain volunteer activities for the patient being cared for at home. These services are given only upon the request or approval of the patient's physician, and consist for the most part of:

- a. Making and distributing dressings, bed pads and other handmade comfort items such as bed jackets, slippers, laryngectomee bibs, etc.
- b. The operation of Loan Closets. The items loaned include certain sick room equipment such as beds, wheel chairs, and small equipment which may be returned and reused.
- c. Supplies volunteer transportation to and from treatment facilities (limited).
- d. Makes available for distribution to physicians free of charge booklets for the care of patients who have had colostomies and mastectomies.

More information may be obtained from your local Committee.

CARDS FOR SCREENING PRE-SCHOOL CHILDREN'S VISION AVAILABLE



Sjogren
Hand Card

The last meeting of the Illinois State Medical Society Board of Trustees approved a cooperative program between the Illinois Department of Public Health, the Illinois Chapter of the American Academy of Pediatrics and the Illinois State Medical Society which is making available to all ISMS members modified Sjogren hand cards. These cards have the image of a hand, calibrated for a 20/30 screening at 12 feet. Instructions are printed on the reverse side of the card for performing a parent-administered screening to three and four year old youngsters at home. The results of this screening are relayed back to the ISMS physician by means of a pre-printed post-card.

A pilot study done last fall by the Illinois Department of Public Health and the Illinois Chapter of the American Academy of Pediatrics revealed that parent-administered screening of three and four year old children done at home may be a feasible and practical method of detecting impaired unilateral vision. Among the thirty-two pediatricians that reported on the results of cards they distributed last fall; six found one or more early cases of amblyopia ex anopsia each, among their three and four year old patients. One of the pediatricians found five cases, all of which were later confirmed by ophthalmologists.

As a result of this pilot study it was agreed to revise and simplify the modified Sjogren hand card and to invite not only the Fellows of the Illinois Chapter of the American Academy of Pediatrics but any member of the Illinois State Medical Society to utilize the service. Accordingly the Illinois Department of Public Health will make available free, to any member of the State Medical Society who requests it, twenty-five copies of the modified Sjogren

hand card together with a pre-printed post-card on which the parent should notify the physician of the results.

If there is a discrepancy in vision between the two eyes with a failure to determine the correct direction in more than four out of six positions with one eye; the possibility of this being an early case of amblyopia ex anopsia exists, and an eye examination by an ophthalmologist would be desirable.

Amblyopia ex anopsia affects approximately three or four per cent of all children in the United States. The affected individuals, because of unilateral refractive error or imbalance of eye muscles or both, use only their better eye for most visual activities. Accordingly the image from their weaker eye is suppressed and not used. As a result, by the time they are five or six years old this sustained disuse has permanently impaired detailed central visual acuity. If this is detected at three or four years of age and the child, with the aid of refractive correction, patching the good eye, or both of these measures, is forced to use the weaker eye; its central visual acuity is not lost. Frequently, these children are able to see well with one eye; poor vision in the other eye is, therefore, often undetected until tested in school at five, six, or seven years of age, when for many it is too late to help. The above test is designed to pick up these early cases through parent-administered tests at home.

If you wish to make use of these tests, you can obtain, free of charge, 25 modified Sjogren Hand Cards, by writing to the Board of Health Education, Illinois Department of Public Health, 505 State Office Building, Springfield, Illinois 62706. There is no obligation other than to let the Illinois Department of Public Health know whether or not it helps, and if so the number and percent of those on whom it is used that are early cases of amblyopia ex anopsia.



DRUGS: THE MEDICAL CARE

PROGRAM'S BIGGEST HEADACHE

Burtis E. Montgomery, M.D.

President, Illinois State Medical Society

SINCE I HAVE BEEN GIVEN A HALF HOUR of your time to discuss welfare drug programs from the physician's point of view, I want to take just a few minutes of that time to question the basic assumption of the panel title—*IS* the drug portion of the welfare medical program a "headache" and, if it is, can it be fairly called the *biggest* headache in the program?

I am not unfamiliar with welfare medical programs. I have been on the Medical Advisory Committee to the Illinois Public Aid Commission, now the Department of Public Aid, for many years, and our advisory committees have had a close working relationship with welfare officials, both at the state and at the local level.

A little later on, I want to talk about our own Illinois Drug program. Now, however, I would like to suggest a little careful consideration of just how big a problem drugs are in a welfare program.

I know the standard complaint is that drugs cost the welfare department too

much, that drug costs are getting out of hand, that they are "uncontrollable." On the other hand, I have checked some of the reports on vendor payments for medical care issued by the division of program statistics and analysis of the bureau of family services.

During 1963, vendor payments identified as for prescribed drugs made up 8.6 per cent of general and public assistance medical expenditures, 9.3 per cent of public assistance medical costs. In 1962, the percentages were, respectively 9.1 per cent and 10.0 per cent. And, just for comparison, in the fiscal year ending June 1958, "Drugs and Supplies" accounted for 13.9 per cent

Editor's Note: Once again because of its importance and in lieu of the President's Page, we reprint in full a speech presented by Dr. Montgomery before the recent Central States Regional Conference of the American Public Welfare Association.

of general and public, and 14.1 per cent of public assistance medical care costs.

I do not plan to get involved in statistics and percentages any more than I can help. However, I do find these figures interesting especially when compared with the dollar amounts expended for these three years—thirty million dollars in 1958, seventy-four million in 1962, and ninety-two million in 1963.

If you look only at these dollar amounts, there seems obvious cause for alarm. Your accountants look at the books and scream, "drug costs have tripled in just five years." But in those same five years, total vendor payments have more than tripled—from 300 million dollars to over one *billion*.

Drug costs have, in fact, not expanded as fast as the program as a whole; they seem somewhat more under control than some of the other cost items in your programs. I don't claim that paying for drugs is no problem; I am merely suggesting that we may have lost our perspective somewhat in making such an issue of a *comparatively* small part of the welfare medical problem as a whole.

There is another aspect of the "drug problem" which I feel, as a physician, has not been fully recognized in some welfare agencies.

I recall, some years ago, reading a newspaper report of a court case dealing with a woman—an aid to dependent children recipient—who had been found to have unreported income. At this distance in time, I do not recall all the details of the case, but I do recall that the welfare department representative at the trial arguing against jailing the woman. His argument was on strictly practical grounds, which I am sure that the welfare representatives here will appreciate.

He pointed out that the cost to the state of Illinois of putting this woman's children in institutions or in foster homes during a one month jail sentence would be more than her total payment from ADC funds for *six* months.

If the parallel is not obvious, what I am trying to say is that the cost of prescrip-

tions should not be considered simply as an added charge on the welfare budget, but in terms of what those drugs are *saving* the welfare department in terms of cost if they are *not* provided.

Like the cost of ADC payments compared with the cost of putting ADC children in foster homes, it is more economical to provide the needed drugs now than to pay for hospitalization and nursing home care two or three months from now. In view of the fact that thirty dollars, or more is not an unreasonable daily rate for hospital care today, almost any prescription which can reduce your hospital use is a bargain.

I make this point because, with total hospital costs and total drug costs for welfare patients both going up annually, it is too easy to think of the prescription as merely another added cost. Actually, if you sift your statistics I would expect you to find that the cost increase in hospitalization results more from higher daily costs than from increased stays; for most conditions the hospital stay has been reduced. And in many cases, new drugs have helped to reduce that stay—or even avoid it entirely.

There is another factor involved in welfare drug programs which tends to further exaggerate the so called "headache." Those of you who have been around welfare programs for a long time realize that prescribed drugs, except as part of the hospital treatment, are a relative latecomer to vendor payment programs. For a long while after the vendor payment method for hospital care was accepted welfare practice the purchase of prescriptions was left to the patient. In some states, his monthly grant might be increased somewhat if he needed medication, but in others he was expected to cut down on his other expenses to pay for drugs.

Change in Financing

There is a gradual change taking place in this approach to financing prescription charges. Between June 1960 and June 1964, seven states began making vendor payments for drugs in one or more of their public assistance medical programs, but a

the end of that period, there were still sixteen states, according to HEW reports, which were making no vendor payments for drugs in their public assistance programs. Four of these sixteen states did make some vendor payments for prescriptions from general assistance funds, but in the remaining twelve the purchase of prescribed drugs was not a formal part of the medical program.

Really a Headache?

To my mind, this also leads to some questioning of the reality of drug costs as a "headache." I wonder whether drug costs are truly so uncontrollable and such a matter of concern, or whether it is more that they are now becoming an identifiable and labelled medical cost, where before they were buried within the total cash grant.

In fact, putting together the statistical evidence that drug costs have *decreased*, as a percentage of total vendor payments, in recent years and the fact that, during the same period, the number of states including drugs in their vendor payment programs has *increased*, perhaps our real question should be whether *enough* is being spent on drugs.

I put this question quite seriously, and I put it because I, both as an individual physician in private practice and as a member of state and national medical committees dealing with care of the needy, have a very clear picture of the growing importance of welfare agencies in the financing of medical care. You in welfare administrations are, of course, well aware of this—in fact, according to some of you to whom we in medicine have talked, the "headache" is not just drugs, but your whole medical care program. I have met some welfare directors who would welcome an aspirin which would eliminate the whole thing from their programs.

In terms of cost, over a quarter of all public and general assistance funds in December of last year went for vendor payments; Illinois' old age assistance program that month spent only 24 thousand dollars more in money payments than in vendor payments, out of a 53 million dollar

total. In the 1963 fiscal year, vendor payments made up about an eighth of all public expenditures for health and medical care, including all health programs at all levels of government, from the local health department to the armed forces hospital network—and a thirtieth of *all* health and medical expenditures, public and private.

And these expenditures would tend to increase, even in the normal course of events, as the cost of adequate medical treatment increases, as the states expand their existing medical programs. The Kerr-Mills MAA program which the medical profession has supported, was taking care of 150 thousand people in December 1963, and 227 thousand in December 1964; its monthly expenditures increased 14 million dollars during that period—and several more states passed the necessary enabling legislation this year.

As you know, we may not be operating within the normal course of events within a short time. The social security amendments of 1965, H.R. 6675, will bring about a drastic forced growth in welfare medical programs.

Don't worry—I am not planning to use this panel to present again the American Medical Association's position concerning this bill. I simply want to point out, as a fact, that the new medical assistance program, title XIX, contained in this bill, will present most state welfare departments with a choice, by June 1967, of a greatly expanded medical care program or no medical program at all.

The Choice

I am sure most of you are aware of the details by now, so I will only note that, if your program does not provide uniform hospital in and out patient services, nursing home care, physicians' services wherever provided, and laboratory services for *all* public assistance recipients by that date, there will be *no* federal matching funds. And, if you retain your MAA program (and I do not see how, in terms of practical politics, any state legislature can discontinue this program once it has been in operation) there must be similar provision

for the medically indigent blind, disabled and needy families.

Further, as condition for federal matching, each state program must go beyond this specified minimum package, aiming at a *comprehensive* program by 1975. I have not yet seen any definition of what "comprehensive" means in this program, but HEW has been classifying MAA programs as comprehensive when they provide hospital and nursing home care, physicians' service, dental care, and drugs "without significant limitations."

I do not want to dwell on this. I am simply trying to get this whole question in perspective—in the context not only of today's welfare programs, but of tomorrow's, which will be even bigger.

In this context, I can state the "physician's headache" in regard to drugs very simply. It may seem almost too simple, in view of the length of my preamble.

The Doctor's Headache

The physician's real headache, as a physician, lies in his patient's not getting the drug the physician considers necessary for proper treatment.

This is, I would say, at the root of almost all conflicts between welfare agencies and physicians in regard to agency control of drug expenditures. It is also at the root of any similar conflicts which might arise in regard to other phases of the welfare medical program, beyond those services the physician himself provides.

The physician is a taxpayer, and he is concerned that his tax funds be spent efficiently and economically; he is also concerned that they be spent effectively. When welfare regulations are such that the skill and time he has devoted to diagnosing an illness or injury and prescribing a course of treatment is partially or wholly wasted, in the name of economy, then he is outraged, both as a physician and as a taxpayer.

I am making no indictment of welfare agencies. When the AMA Committee on Welfare Services (then named the Committee on Indigent Care) and your association's subcommittee on drugs worked together in

1959 and 1960 on the "guides for drug expenditures for welfare recipients," adopted as official policy by both associations in 1960, I was not yet a member of the committee. However, from my own experience, I must concur heartily in the emphasis placed by those guides of liaison between welfare agencies and the medical profession.

You may recall that the guides are divided into three sections, outlining public welfare agency responsibility, medical profession responsibility and patient responsibility. In the first section, the agency is reminded that "the soundest program is one conceived and administered with the help of a medical director or consultant, and with the aid and support of an advisory committee representing the medical profession." The second section points out that "the medical society, for its part, should maintain an adequate, cooperative and responsible liaison with the welfare agency."

Frankly, I believe that these two statements are the most important in the whole guides, both for an effective drug program and for an effective medical care program, if the private practitioner is to be involved in it at all. Mechanisms of control, whether in the form of dollar limits on prescriptions, formularies, prior authorization, or of computer analysis of prescribing habits, are all secondary to the basic question of whether honest liaison exists between the agency and the physician.

This is not simply a philosophical theory; it is a fact attested to by both medical associations and welfare departments. Where the liaison does not exist, the physician distrusts the agency and the agency sees its role as a rigid, authoritarian one, forcing its regulations on the practitioner. Where the two work together, both feel far greater satisfaction with the medical care provided the needy through their joint efforts.

We have had some experience of this in Illinois. We physicians feel that, on the whole, our relationship with the Illinois Public Aid Commission and now with the Illinois Public Aid Department has been a

productive one. Our medical advisory committees have been seriously consulted on medical policies of the department and our advice and comments have been heeded.

From the welfare department's viewpoint, Mr. Hilliard volunteered the information, at the last meeting of the committee on welfare services, that the medical advisory committees had greatly aided the department in its administration of medical care.

Perhaps an even more practical proof of what effective liaison can mean was demonstrated at the AMA national conference on Kerr-Mills, held this January in Chicago. To ensure nationwide attendance at this conference, the association paid expenses for two representatives from each state medical association—and at least two state medical associations sent their welfare director as one of the association representatives.

You can't get much closer liaison than that.

One section of the guides, referring to the welfare agency's responsibility, states, "whatever methods are used to reduce expenditures, leeway must be left for exceptions, when medically justifiable, and for appeal of agency decisions by the attending physician."

I think this "leeway" will follow naturally from any really effective liaison. When the welfare agency and the physicians meet as partners in the medical program, the effect of too-rigid regulation of the drug program can be clearly presented to the welfare representatives, while, at the same time, the medical profession's cooperation is enlisted in keeping the program within reasonable bounds. (AD. LIB. development of Illinois Drug Manual.)

I think it would be worthwhile if I try to summarize what I have said so far, much more briefly.

First, I think that the so-called "head-ache" of drug costs has been magnified out of all proportion. Although it may be a problem, it is only part of the greater problem of generally rising costs. You in welfare know that, in many states, the cash grants are really inadequate, in terms of

today's living costs; the budgets on which allowances for food, clothing and shelter are based may be years out of date. Yet this money *does* pay for some food, some clothing, some shelter—even if not enough, still better than nothing.

A lot of welfare programs either don't pay the physician at all, or pay him for only some of his services, or pay him fees that were common twenty years ago. Well, you know that most physicians won't drop a patient simply for that reason; we have guaranteed that no patient will go without physicians' care simply because of inability to pay. Likewise the hospitals are still providing a good deal of care to welfare patients which is not met from the welfare department's budget—some of it is paid for by the other patients, some by community funds and philanthropy.

Less Is Worse Than None

But the drug question is something else again. At least in some cases, providing less than the prescription needed is no better than providing no drug at all. And while pharmacists, too, are providing a considerable amount of drugs to the needy at reduced rates, theirs is a profit-and-loss business; they cannot continually supply the needy out of their charity any more than the local grocer can supplement out of his stock the welfare department's food budget.

Second, no *mechanism*, by itself, can solve your problem. If you take a formulary developed in some other state and inform the physicians in your own state, that, "this is how we are going to work things here," you will have a revolution—either a loud or quiet one. The medical association may refuse to go along with you, or individual physicians may just drop out of your program and treat patients with no reference to welfare rules.

This is no solution, either, since it brings back the situation the vendor payment programs were instituted to avoid—the physician recommending a specific course of treatment which the patient does not follow, simply because he does not have the money for it.

Whatever solution you seek, it *must* be a joint solution, arrived at by the welfare agency and the physicians, working together, or it will subvert the basic purpose of the program—the provision of adequate care to the needy.

Thirdly, you must recognize that the prescription is an important, and often the *essential* part of medical treatment. Despite all the Readers' Digest-type publicity about "wonder drugs," I don't think this is yet fully realized by many people.

When we, as physicians, say "you need surgery, at once," most people don't argue; they start making arrangements to go into the hospital. When we prescribe hospitalization, for non-surgical reasons, our decision is accepted. But when we prescribe a specific course of drug treatment, it is sometimes not realized that this is as much a form of treatment as hospitalization or surgery and that it is just as necessary, medically, that our recommendation be followed.

Importance of Drugs

You cannot shirk prescriptions and receive adequate care, any more than you can ignore the physician's recommendation for surgery.

I believe that this failure to recognize the importance of prescribed drugs in treatment has a good deal to do with the so-called headache of drug costs.

Can any of you picture telling a doctor who recommended heart surgery, "why don't you do an appendectomy instead? It's a lot cheaper."

For that matter, can you picture a welfare agency putting an over-65 client in the aid to needy families program, because the average grant is smaller?

This gets down to the really basic controversy, where one exists, between physicians and welfare agencies on drug costs. We are willing, indeed we are anxious to prescribe economical drugs for our patients, whether on welfare or paying their own way—but it has to be the *right* drug. It is when we are denied the opportunity to provide for our patients the proper drug for

their treatment, simply on a basis of cost, that we rebel.

It is for this reason that the guides contain so many safeguards for the physician's right to prescribe as he sees fit. The recommendation for "leeway" in controls I have already cited; in our recommendations to physicians, we again consider the matter and suggest that the physician examine his own prescribing habits to determine whether effective care can be given more economically.

You will notice here that the emphasis, really, is on greater physician knowledge of costs and alternative methods. We recommend use of standard quantities of drugs, to avoid the extra cost of broken packages; we recommend realistic limits on refills, since some studies indicate that unneeded refills constitute the major excess cost in drug therapy.

On the actual drugs to be prescribed, the wording is very precise and very careful. Let me quote you the exact phrasing:

"Emphasis on the use of U.S.P., N.F., N.N.D. and A.D.R. counterpart drugs of equal therapeutic effectiveness when available, when the quality of the product is assured and when a price differential exists."

If you look at the wording, you will see that it places on the physician the burden of being sure that the drug with which his prescription is filled will do the job he wants it to—he must be sure of the therapeutic effectiveness, he must be sure of the quality, before he chooses the cheaper drug. This is his *professional* responsibility, and he cannot relinquish it to those outside the medical profession.

The Generic Problem

Here lies the real problem with prescribing by generic names, which is more and more presented as the solution to drug costs. If I am sure that any manufacturer's form of the drug will do the same job and have the same side effects, I am justified in prescribing by the generic name. If I know that various forms of the drug are differently compounded, have different inert

ingredients which may affect my patient, have different quality controls, then I need to specify which forms may be used.

This variation *does* exist in drugs with the same generic name. Even in aspirin, which most physicians will prescribe without specifying brand, there are differences—in the rate of dissolution, for instance. In the great majority of cases, it doesn't matter much which brand of aspirin you use—but in some drugs, it can make a very considerable difference.

It is for this reason that we place such an emphasis on the individual physician's right of choice, since he is responsible for the effects of his prescription. This responsibility is legally recognized by legislation in the various states which makes it a criminal offense for a pharmacist, who is professionally trained to compound prescriptions, to substitute another drug for the one prescribed—including substitution of another manufacturer's form of the same drug on a brand-name prescription.

I really believe that many physicians would welcome the chance to use generic names in prescriptions, and leave it to the pharmacist to decide which brand—if they could be *sure* that the effect on the patient were the same, just as pharmacists would welcome the opportunity to cut down on the number of drugs they have to stock.

But that day has not yet arrived and, until it does, we must remain concerned that too much emphasis on price does not lead to lack of concern for quality.

Look at the matter like this—the Sears Roebuck catalog lists phonographs for prices ranging from under fifteen dollars to

over five hundred. They all have the same generic name—"phonograph"—and they can all play the same record, but you don't just order a "phonograph" and let the store decide which one to send you.

If all you want is something for your six-year-old to play twenty-five-cent children's records on, the fifteen-dollar one will do fine. If you want one for your teenager's mersey beat records, then the thirty-dollar portable will do, especially if it's not too loud. But if you are a Hi-Fi addict, with a collection of symphonic and opera albums worth thousands of dollars, you look for the instrument which will do them justice.

It is the same way with drugs. In some illnesses, it does not matter too much which brand of a drug you use: In others a slightly greater degree of selectivity is needed: and, in some cases, the physician can be *sure* of getting the results he seeks only by specifying a particular brand name.

This must be recognized. And the need for leeway, as we have called it in the guides—the need for recognition that the prescription is part of the physician's professional responsibility. That too-rigid control of what he may prescribe prevents him from doing his job properly and in the long run, wastes, rather than saves the taxpayers' money.

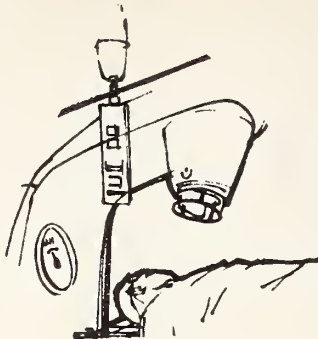
If this is recognized, and cost controls are developed jointly by welfare and the medical profession in a spirit of mutual respect and cooperation, the "physician's headache"—at least so far as this part of the program is concerned—will practically disappear.

Coming Next Month:

BLOOD GROUP INCOMPATIBILITY OF THE NEWBORN: RECENT ADVANCES

Israel Davidsohn, M.D.

Medical Progress



HARVEY KRAVITZ M.D./progress editor

ACUTE AND CHRONIC GERMAN MEASLES

Lon R. White, M.D. and
John L. Sever, M.D./bethesda, maryland

THE MAJOR CLINICAL SIGNIFICANCE of the rubella (German measles) virus relates to its peculiar ability to inflict catastrophic damage upon the developing human embryo. The characteristic malformations which can result include cataracts, chorio-retinitis, deafness, congenital heart disease, microcephaly and mental retardation. In addition, this virus frequently persists in the fetus and newborn long after resolution of maternal illness and despite high levels of circulating antibody. Such infants may act as the "Typhoid Marys" of German measles and may show a characteristic acute illness at birth and during the neonatal period.

It has been estimated that as many as twenty thousand infants having some or all

of these stigmata of congenitally acquired rubella may have been born in this country as a result of the epidemic which struck the United States in 1964¹. The results of the 1965 epidemic in the midwest, west coast and Hawaii are not yet known.

German measles is a mild, three or four day exanthematous illness which occurs most often in childhood or adolescence. Because of its benign course, it is seldom of concern to the practicing physician except when the host (potential or actual) happens to be a woman in the first trimester of pregnancy. A clear understanding of the pathogenesis and epidemiology of the disease then becomes essential to an intelligent assessment of fetal risk and to the planning of subsequent treatment.

Acute German Measles

Infection with rubella virus almost always confers complete, long-lasting immunity as reflected by persistence of high levels of neutralizing antibody for years after infection. The "second attack" is probably

Section on Infectious Diseases, Perinatal Research Branch, National Institute of Neurological Diseases and Blindness, and the National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, Maryland.

a very rare occurrence. In the United States, most individuals encounter the infection during childhood or adolescence with the frequency of antibody to rubella increasing from approximately 35% among children one to ten years of age to 85% in the age groups sixteen to twenty-five years and older². Approximately the same prevalence of immunity has been found among pregnant women from several metropolitan areas³. In that study, a fairly consistent susceptibility rate of from 15 to 25% was demonstrated. A lack of correlation of history with serological findings in these women suggested that neither the presence nor the absence of a history of previous German measles is of great value.

In the epidemic situation, the communicability of German measles among exposed, susceptible individuals may approach that of regular measles (rubeola)⁴. When infection does occur, post-auricular and/or suboccipital lymphadenopathy is almost always observed, even in the absence of the rash⁵. The frequency of "subclinical" disease diminishes as the age of the host increases so that among women of child-bearing age, approximately one-third to two-thirds of infections occur without a rash. The period of communicability may last from several days before to several days after the appearance of the skin lesions. In the case of rubella with nodes only, the period of communicability is difficult to determine and does not correspond to adenopathy.

These generalizations were substantiated by a study conducted on St. Paul Island in the Pribilofs, Alaska, in 1963^{4,5}. Until the epidemic which occurred that summer, rubella had been absent from the community for more than 20 years. Among the villagers who were old enough to have been present during the previous epidemic, there were only a few cases of German measles; among the younger members of the community, most showed evidence of infection.

During the epidemic, an intensive investigation focused on 23 male and 23 female individuals, all under 19 years of age. Each was examined and a throat swab obtained daily. Serum specimens were obtained at the outset, at the termination of the inten-

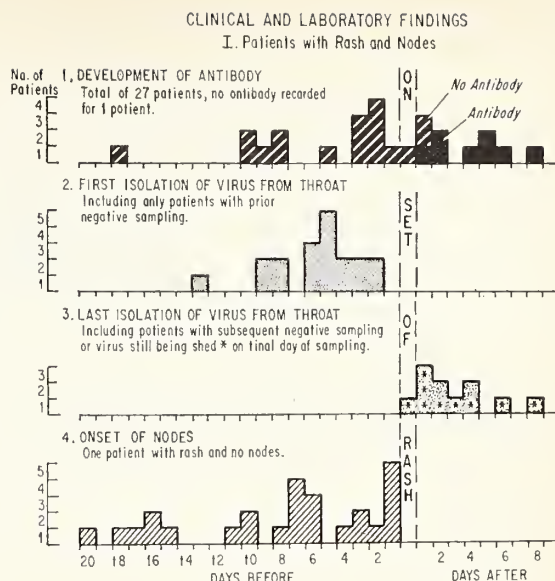


Figure 1.

sive study period and again three months later.

All of the 46 patients were initially susceptible and all experienced infection as evidenced by the development of antibodies. As shown in Figure 1, neutralizing antibodies were first detected on the day after the onset of the exanthemata and persisted in all subsequent sera. In the patients with nodes only (Figure 2), antibody was first found five days after the appearance of nodes, although some patients were still without detectable antibody as late as 12 days after the onset of adenopathy. Isolation of virus from nasopharyngeal cultures was accomplished from 80% of the patients who developed rash and from 50% of those who had rubella with nodes only. Approximately 60% of patients had a typical illness with rash and lymphadenopathy while 40% had infection with nodes only and one individual developed no clinical evidence of rubella.

The earliest positive culture was obtained 13 days prior to the onset of rash; the majority of patients with classical German measles had virus isolated from the nasopharynx five days before rash. All individuals tested continued to shed virus from the nasopharynx for at least two days after the rash appeared, with some patients still shedding after six days. In the absence

CLINICAL AND LABORATORY FINDINGS

II. Patients with Nodes only

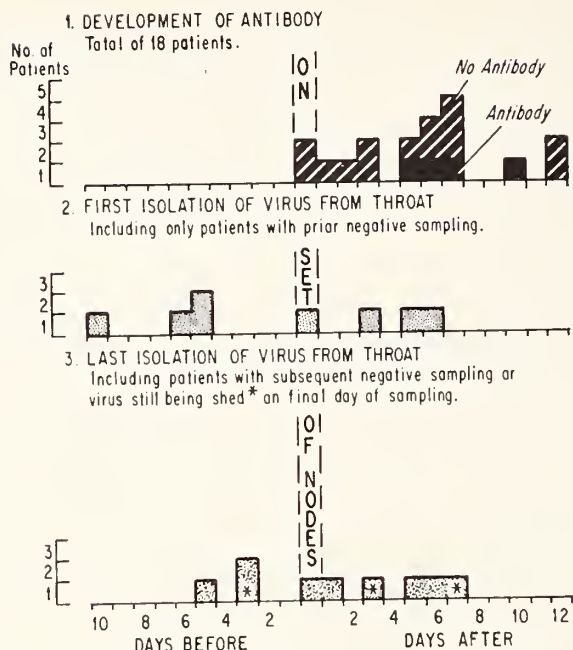


Figure 2.

of rash, there was no predictable relationship between the onset of lymphadenopathy and the isolation of virus from nasopharyngeal cultures. The duration of persistence of virus in the nasopharynx was not determined in all cases; however, virus was present for as long as nine days in individuals with the full clinical picture of nodes and rash. In the patients with nodes only, the longest persistence of virus was four days.

Enlarged posterior auricular and/or suboccipital nodes were noted as early as three weeks before the rash with the majority of patients having typical adenopathy one to two weeks before the onset of skin lesions. All had nodes by the day before the rash.

In a study of the effects of the 1964 rubella epidemic on 6,161 pregnancies, ten per cent of the women studied reported exposure to German measles during the first trimester while 2% of the total population developed clinical illness⁶. Following known first trimester exposure, 3% of the women had clinical rubella and 6% had clinically inapparent disease diagnosed by seroconversion. Only 45% of the women with clini-

cal rubella during the first trimester knew of exposure during the previous two to three weeks.

These findings emphasize that: 1. in urban areas of the United States, 15 to 25% of women of child-bearing age are susceptible to rubella; 2. with heavy exposure, the susceptible individual usually becomes infected; 3. once infected, one-third to one-half of such individuals will develop a rash 1 to 2% will show no sign of disease and the remainder will show lymphadenopathy as their only evidence of infection.

Consequences of Intrauterine Infection

Once a woman in the early stages of pregnancy acquires German measles, a number of outcomes are possible. The relative and absolute frequencies with which these possible outcomes occur are not yet known; however, it may be assumed that subsequent to maternal viremia, placental infection may or may not occur (it probably does in most cases), fetal infection may or may not follow (it probably does in about one-third of cases), live virus may or may not persist in fetal tissues as a chronic infection, the pregnancy may or may not result in livebirth and clinical disease may or may not be apparent after birth.

At the present time, we are aware of three distinct but overlapping clinical syndromes which result from intrauterine rubella and two of these reflect chronic infection.

The Congenital Rubella Syndrome

The defects which can occur as a consequence of intrauterine infection with the rubella virus have already been mentioned. The *congenital rubella syndrome* is represented by any or all of these defects in association with a history of maternal rubella during the first three or four months of pregnancy. The type, severity, and risk of occurrence of these abnormalities is a function of the gestational age at the time of infection and seems unrelated to the severity of maternal illness. In general, the risk of congenital malformation falls from approximately 50% during the first week to about 3 to 5% when the rash occurs during the twelfth week of gestation. When

maternal infection occurs without rash, the risk is uncertain^{6,7}.

It is generally believed that these congenital defects are the direct result of virus infection of embryonic cells at a critical time and site during organogenesis. A peculiar susceptibility of these cells to the rubella virus may be crucial to the pathogenesis of the malformations. That such a peculiar susceptibility may indeed exist is reflected by frequent persistence of infection in the fetus long after the virus has been eradicated from maternal tissues.

Chronic German Measles

Although German measles in the child or adult is an acute, self-limited disease, this is not the case when the host is the developing human embryo. Once the virus gains a foothold in embryonic tissues, it is often, perhaps usually, able to persist throughout fetal life and even for several months after birth^{8,9}. The relationship between maternal, placental and fetal infection is illustrated in Figure 3. It is not yet known how frequently this occurs after subclinical maternal infection, if it can occur with maternal infection later in pregnancy, or

even if it might occur in the immune mother, although this seems very unlikely. This chronic infection has been shown to involve many different organs; however, the only consistently recognized clinical correlate has been retarded growth and failure to thrive although "ripening" of congenital cataracts, apparent progression of central nervous system disease and a malabsorption-like picture may sometimes be seen.

The first suggestion that live virus might persist in the products of conception came with Seltzer's report of recovery of the rubella virus from the aborted fetus of a woman who had had German measles during the first trimester of pregnancy¹⁰. In our studies, virus was isolated from more than 60% of 50 fetuses obtained by therapeutic abortion following maternal rubella⁸. Since that time, we have expanded our series with essentially the same frequency of virus isolation. In one instance, the virus was recovered from almost every organ of a fetus obtained 77 days after maternal infection. At the same time, this mother's serum contained a high level of rubella neutralizing antibody.

ACUTE AND CHRONIC RUBELLA

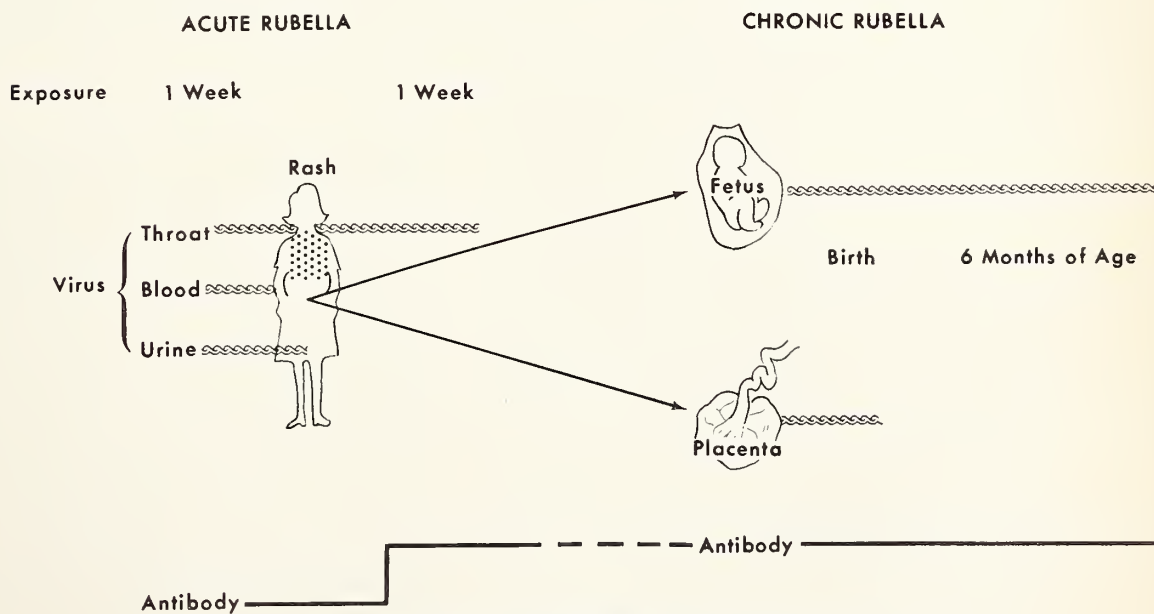


Figure 3. Relationship of maternal infection and antibody to placental and fetal infection.

In 1964, Alford et al. reported isolation of the virus from several children with congenital rubella syndrome who were 1 to 4-1/2 months of age¹¹. We have confirmed this finding in a number of children and have extended their observations by post-mortem isolation of virus from multiple tissues of three children with congenitally acquired rubella infection who died at ages 22, 27, and 59 days⁹. A striking dissemination was reflected in positive cultures from lung, brain, kidney, spleen, adrenal, pancreas, thyroid, eye and thymus tissue. In only a single case was virus recovered from the liver and no isolations were made from cardiac tissue.

The usual duration of infection has not yet been determined. However, the persistence of virus shedding does appear to be limited, since we have thus far been unable to isolate rubella virus from the blood, urine or nasopharynx of children with the congenital rubella syndrome ranging in age from 5 to 23 years¹².

Acute Congenital Rubella of the Newborn

Many of these chronically infected infants (including some with congenital malformations) are acutely ill during the neonatal period with severe, multisystem disease. Petechiae, hepatosplenomegaly and long bone radiolucencies are the most striking findings and are often present at birth¹³.

The hematologic abnormalities found in these infants include thrombocytopenia, anemia, lymphopenia and occasional hemolysis, while the hepatomegaly has been shown to represent a true hepatitis with regurgitative features¹⁴. The linear, radiolucent long bone lesions have not yet been adequately explained although at least one investigator has observed osteoclastic activity in the area of such a lesion¹⁵. In addition, myocarditis, encephalitis and interstitial pneumonia have been reported^{14,16}.

Most often these abnormalities begin to clear spontaneously after a few weeks despite continued shedding of the virus from the nasopharynx. The factors which are responsible for this clearing are as unknown as those which allow the rubella

virus to persist in the presence of high levels of neutralizing antibody.

Summary

From the results which have been described, it is apparent that when a child or adult is exposed to German measles, his risk of infection depends upon the density of exposure and his pre-existing state of immunity to rubella. With heavy exposure, most susceptible individuals will become infected but only about one-third to one-half will develop skin lesions; however, almost all will develop characteristic lymphadenopathy.

Once a woman in the early stages of pregnancy becomes infected, fetal infection may or may not follow and may or may not cause significant disease. If livebirth occurs, the product may be normal, may harbor a chronic infection with the rubella virus, may show congenital malformations and/or may show a characteristic acute illness during neonatal life.

The occurrence of chronic German measles as a consequence of intrauterine infection has come to be appreciated only recently. The peculiar susceptibility of these infants to persisting rubella infection, the pathological consequences of chronic infection and the total significance of this phenomenon are currently the object of intensive investigation.

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NEW TEST FOR MONONUCLEOSIS

A faster, more accurate test has been developed for infectious mononucleosis, reports a current issue of the Journal of the American Medical Association.

The new test can be done in less than two minutes in a physician's office, compared to the 1½ to 5 hours required by the earlier method (which could only be done in a hospital where equipment was available).

The new test further reduces the possibility of misdiagnosis of what some college students jokingly refer to as "the kissing disease." Infectious mononucleosis, whose cause is unknown, seems to be transmitted by close personal contact. It is usually a mild disease characterized by fever, sore throat, and lymph node enlargement.

The importance of correct diagnosis, however, is no joke. Mononucleosis symptoms resemble those of other, more serious diseases, such as acute leukemia, hepatitis, and forms of meningitis and encephalitis. Meningitis, for instance, requires prompt and specific treatment different from that used against mononucleosis; the wrong diagnosis could have serious consequences.

Up to now, the best and most widely used test for mononucleosis has been the Paul-Bunnell test, which is based upon the fact that the blood serum of a person infected with mononucleosis will react with an antigen in the red blood cells of sheep. The serum makes these cells agglutinate, or clump together. Thus, if a person's serum clumps sheep red cells, the diagnosis is infectious mono.

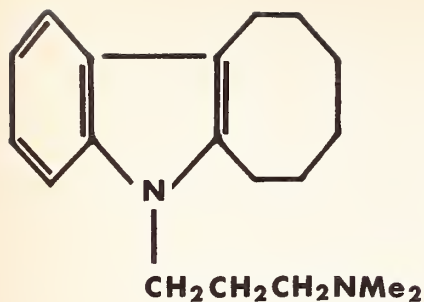
The Paul-Bunnell test, however, is complicated, takes a long time to perform, and sometimes must be followed by another test. Finally, there are an estimated 10 to 15 per cent false positive reactions (indicating a person has mononucleosis when he doesn't) and a smaller percentage of false negative reactions.

The authors of the Journal article began looking for a more specific test. Miss Gail Hoff, a doctoral candidate in zoology at Rutgers University and a technician at the Princeton Laboratories, in New Jersey, and Stanley Bauer, M.D., of the Princeton, N.J., Hospital, tested several types of animal cells.

Blood cells from horses were found to be the most satisfactory, and the authors developed chemical means of stabilizing them so that they can be furnished in a kit instead of drawn fresh. The Paul-Bunnell test requires fresh sheep cells.

Using the new test in 426 cases suspected of infectious mononucleosis, the correct diagnosis was reached in 98.5 per cent, a far higher percentage than would be likely with the earlier method. In 250 cases, there were false negative reactions in only 0.4 per cent, compared with 9 per cent reported in studies of the older test.

The three advantages of the new test, the authors said, are its low incidence of false reactions, a highly specific reaction to the infectious mononucleosis antibody, and great rapidity and ease of performance.



IPRINDOLE, A NEW ANTIDEPRESSANT FOR USE IN GENERAL OFFICE PRACTICE

A DOUBLE BLIND, PLACEBO-CONTROLLED STUDY

James T. Hicks, M.D./oak park

ALTHOUGH DEPRESSION has been recognized as a psychic entity for nearly three hundred and fifty years, and today is the most prevalent, persistent disorder of the emotions and thought processes,¹⁻³ there is still little known about the cause^{4, 5} or the mechanism. A neurophysiological theory for the origin of depression has been advanced by Stein,⁶ who believes that the depressive state results from abnormal hypoactivity of the reward centers of the brain.

Electroshock therapy, formerly the standard, is not suitable for the less severe depressions or for outpatients,⁷ and is attended by a higher mortality^{8, 9} than use of the antidepressant compounds. Such agents fall into three main classes: (1) The pure central nervous system stimulants (analeptics, as amphetamine and methylphenidate), which are of little long term benefit in treatment of established depressive reactions. Many psychiatrists believe amphetamine and its derivatives should not be prescribed for this purpose.¹⁰ (2) The monoamine oxidase inhibitors, e.g., the hydrazine group, which have been successfully used in endogenous depressions. These

induce changes in the neuroamine balance of the brain, particularly norepinephrine and serotonin. However, it never has been established that increase of neuroamines is directly related to the influence of such agents on clinical depression. (3) The compounds of imipramine type, which are indirectly related to the phenothiazine derivatives. These apparently act by enhancing adrenergic activity in the central nervous system. Whereas central stimulants directly facilitate self-stimulation in animals with electrodes permanently implanted in the hypothalamus and midbrain, imipramine and similar substances alone exert no direct effect, but their action is reflected in potentiation of the stimulation produced by amphetamine or methylphenidate.¹¹

It has been postulated that the antidepressive effects of imipramine type may be attributed to increased levels of free norepinephrine, induced by blockage of norepinephrine uptake into storage sites.¹² The mechanism may involve reduction in permeability of the membrane at the

storage site, or possibly interference with an active transfer mechanism.¹³

An N-substituted cycloalkylindole bearing the generic designation iprindole (Wyeth Laboratories, Philadelphia, Pa.)—5-[3-(dimethylamino) propyl]-6, 7, 8, 9, 10, 11-hexahydro-5H-cyclooct [b] indole¹⁴ (Figure, page 622)—appears to possess psychopharmacological activities similar to those of imipramine. The compound has been studied *in vivo* by three standard methods, which measured the influence of the substance on motor, morphine and reserpine activity.¹⁵ In doses at which imipramine is depressant, no significant reduction in motor activity was observed, although the results obtained in the morphine and reserpine tests resembled those produced by imipramine. The weight loss test¹⁶ also was performed. This method is based on the observation that amphetamine suppresses appetite and increases motor activity of the experimental animal, thus reducing body weight, and that such action is potentiated by pretreatment with an antidepressant. Amphetamine-treated rats premedicated with iprindole lost about one and one-half times as much weight as did those that had received imipramine.¹⁶

Iprindole significantly potentiated the action of amphetamine in rats working for rewarding brain stimulation, and potentiated the threshold-lowering response of amphetamine in a manner resembling the potentiation produced by imipramine.¹³

The anticholinergic and antihistaminic effects of iprindole were considerably less than those of imipramine, which led to the expectation of fewer side effects than those seen in clinical use of other antidepressant substances.¹³

Since animal experiments promised a considerable clinical usefulness of the compound, a placebo-controlled investigation was planned in a series of depressed office patients.

Methods and Materials

Fifty-seven ambulatory patients were seen in a private general practice. All were treated for depressive symptoms. The

medication was administered in the form of identical-appearing 15 mg. tablets, which were dispensed in randomly numbered but otherwise unlabeled bottles. Enough tablets were supplied under each number to provide six to eight weeks of treatment. Thus cross-overs were avoided. The code was not in the possession of the physician for the first three weeks, after which it was supplied but was not broken until after treatment had been terminated. Therefore, the study was completely blind.

Before start of treatment the patients were examined for the presence of 17 target symptoms, which, in the order of frequency were as follows: despondency and sadness, psychomotor retardation, fatigue, disinterest, helplessness, ambivalence, slowing of speech, disorders of thought content, delusions or hallucinations, hypochondriasis, insomnia, anorexia, suicidal drive, muscular rigidity, headache, crying and tremors.

The severity of each, if present, was graded as 2 (slight), 3 (moderate), or 4 (severe). A grading of 1 indicated absence or disappearance of a symptom; and 5, deterioration to worse than the basic level. A global evaluation of over-all ability to function also was performed. Thereafter their symptoms were evaluated at frequent intervals, during each return visit to the office. A final global assessment was done after medication was stopped.

Blood pressure and weight were determined before, once during and at termination of treatment. Blood and differential counts were done before start and after cessation of medication. Tests of liver function (thymol turbidity, cephalin flocculation, alkaline phosphatase and transaminase) and urinalyses were performed at the same time.

When the study was terminated, and the code was supplied to the examiner, it was found that the series fell into two comparable groups: Group A, in which the patients received iprindole; and Group B, in which a placebo was administered.

Group A

This segment of the series numbered 29 patients, of whom 15 (52 per cent) were

TABLE 1

Diagnoses for 57 Patients Treated for Depressive Symptoms.

Type of Depression	Group A No. Patients	Group B No. Patients
Senile	11	4
Reactive	7*	3
Psychoneurotic	7	7
Agitated (with anxiety)	3	7
Manic-depressive (psychotic)	1	5
Involutional	0	2
	29	28

*1 had multiple sclerosis

men, and 14 (48 per cent) were women. Their ages ranged from 20 to 86, with an average of 59 years. Seventeen (59 per cent) were 60 years of age or older. The diagnoses are listed in Table 1. Senile and psychoneurotic depressions predominated.

A total of 301 symptoms, varying in severity from 2 to 4, were observed initially in this group. One to 9 grade 4 symptoms were present in each patient, with an average of four; and one to seven grade 3 symptoms, also with an average of four. Sixty-three per cent of the total symptoms were classified as of grade 4 or 3 severity. (Table 2.) Three patients exhibited slight to moderate suicidal drive.

Dosage. The first patient in this group received three tablets of 15 mg. per day for six days; and the next three, four tablets of 15 mg. per day for seven days. The dose then was raised to six tablets (two tablets three times a day), for a total daily dose of 90 mg., which was continued for fifteen to twenty-one days.

The subsequent 25 patients were started on a total dose of 90 mg. per day, which was continued throughout medication.

Duration of treatment ranged from ten to sixty-two days, with an average of thirty-one days. Eighteen patients (62 per cent) remained under medication twenty-eight days or longer. Each received an average of six examinations, conducted at five to seven day intervals.

Group B

This comprised 28 patients, 22 (79 per cent) of whom were men; and 6 (21 per cent), women. They ranged in age from 15 to 82, with an average of 45 years. Six

(21 per cent) were 60 years of age or older. Psychoneurotic and agitated depressions predominated. Four patients exhibited slight to moderate suicidal drive. (Table 1.)

A total of 278 symptoms, varying in severity from 2 to 4, were observed initially in this group. One to 8 grade 4 symptoms were present in each patient, also with an average of 4; and 1 to 5 grade 3 symptoms, with an average of 3. Sixty-four per cent of the total symptoms were classified as grade 4 or 3. (Table 2.)

Dosage. Twenty-seven patients received 2 tablets three times a day; and 1, 2 tablets four times a day.

Treatment was continued for nine to forty days, with an average of twenty-five days. Ten patients (36 per cent) remained under medication for twenty-eight days or more.

Two to six examinations, with an average of four, were performed at intervals of three to fourteen days, with an average of once a week.

Results

The results of treatment, i.e., change in

TABLE 2

Target Symptoms Present in 57 Patients Treated for Depression.

Symptom	Group A 29 patients	Group B 28 patients
Despondency and sadness	25	28
Psychomotor retardation	22	22
Fatigue	27	26
Disinterest	27	27
Helplessness	26	25
Ambivalence	23	23
Slowed speech	21	17
Disordered thought	23	22
Suicidal drive	3	4
Delusions or hallucinations	5	8
Hypochondriasis	27	21
Insomnia	26	26
Muscular rigidity	6	2
Anorexia	23	17
Headache	14	9
Crying	3	0
Tremors	0	1
	301	278
Severe (grade 4)	32%	39%
Moderate (grade 3)	31%	25%
Slight (grade 2)	37%	36%
t-test N.S.		

TABLE 3

Change in Symptoms Effected by Medication.

	Group A	Group B
Result of Treatment	No. Patients	No. Patients
Symptoms improved,		
grade 4 to 1	41	1
4 to 2	31	11
4 to 3	16	29
3 to 1	50	4
3 to 2	47	21
2 to 1	96	19
Symptoms unchanged,		
grade 4	8	54
3	5	41
2	7	70
Symptoms worsened,		
grade 2 to 4	0	5
2 to 3	0	10
3 to 4	0	2
2 to 5	0	2
3 to 5	0	1
4 to 5	0	8
Total symptoms	301	278
Symptoms eliminated (change to grade 1) improved	187 (62%)	24 (9%)
(change from grade 4 or 3 to 2) improved	78 (26%)	32 (12%)
(change from grade 4 to 3)	16 (5%)	29 (10%)
Symptoms unchanged	20 (7%)	165 (59%)
Symptoms worsened (grade 2 to 3 or 3 to 4) aggravated to worse than basic levels	0	17 (6%)
(grade 2, 3 or 4 to 5)	0	11 (4%)
	301	278
All comparisons t-test, $p = <.05$		

target symptoms effected by the active medication in comparison with that produced by placebo are shown in Table 3. In all categories, iprindole was significantly more effective than placebo ($p = <.05$).

The symptoms most consistently and significantly eliminated or reduced by iprindole were: despondency and sadness, psychomotor retardation, fatigue, disinterest, helplessness, insomnia, hypochondriasis, anorexia, ambivalence, crying, muscular rigidity and headache.

The symptoms most resistant to alteration were slowing of speech and disorders of thought content (10 patients).

Under active medication, improvement was first observed in one week, 47 per cent; in two weeks, 24 per cent; in three weeks, 17 per cent; and in four weeks, 12 per cent.

Placebo treatment favorably altered despondency and sadness, psychomotor retardation, fatigue, anorexia, helplessness and ambivalence. All usually had been present initially in slight degree (grade 2). Other symptoms were unaffected or worsened.

Favorable response to placebo, when it occurred, usually was seen in the first week (68, or 80 per cent of the 85 improved symptoms); eight, or 10 per cent, improved in two weeks; seven or 8 per cent, in three weeks; and two, or 2 per cent, in four weeks. Fifteen symptoms (22 per cent) of the group that had improved in the first week relapsed in the third or fourth week.

The results observed in the post-treatment global rating are shown in Table 4. Ninety-three per cent of iprindole-treated patients obtained significant global improvement ($p = <.05$) whereas 75 per cent of the placebo-treated failed to change or became worse.

Laboratory Studies

The blood picture, results of liver function tests and urinalyses showed no abnormalities throughout medication of both groups. One psychoneurotic patient in group A, who had known allergic tendencies, showed a slight eosinophilia before and during treatment. Elevation of eosinophils was seen also in another of this group, and in one of group B (placebo).

No hypotension or abnormal rise in blood pressure occurred in either group. Group A contained two hypertensive patients, whose blood pressure approached normal levels at end of medication. Group B included one grossly obese hypertensive man,

TABLE 4

Post-Treatment Global Rating of 57 Depressed Patients.

	Group A	Group B
	No. Patients	No. Patients
Improvement		
Excellent	22 76	3 11
	93	
Moderate	5 17	0 0
Slight	0 0	4 14
None	2 7	10 36
	75	
Worse	0 0	11 39
Total patients	29	28
t-test $p = <.05$		

whose blood pressure remained elevated throughout and at end of medication.

Treatment appeared to have little or no influence on weight in either group. In group A five patients gained one to eight pounds (this last patient had been underweight initially), and three lost one to five pounds. Among the controls, six gained two to five pounds and five lost one to two pounds.

No side effects developed in either group.

Iprindole appears particularly safe for the depressed senile patient.

Summary

Experimental studies have shown that iprindole, an indole compound closely allied to imipramine, significantly potentiates the action of amphetamine and lowers the threshold response in the reward centers of the brain of animals.

In a double blind, controlled clinical investigation, 29 office patients were treated with 15 mg. tablets of iprindole for depressive symptoms. Twenty-eight comparable patients received placebo. Both groups were mainly men; the iprindole-treated patients were somewhat older than the controls (59 per cent versus 21 per cent were 60 years of age or more.)

All patients were examined for 17 depressive symptoms before, at five to seven day intervals during, and at end of treatment. The most satisfactory total daily dose of iprindole proved to be 90 mg. The active medication was continued for an average of thirty-one days; the placebo, for an average of twenty-five days.

Ninety-three per cent of symptoms were eliminated or satisfactorily reduced by the active medication, whereas only twenty-one per cent of symptoms in the controls showed desirable alteration (t-test, $p < .05$). Similarly, improvement in the global rating

occurred in 93 per cent of those who received iprindole, whereas 75 per cent of the controls showed no change or became worse (t-test, $p < .05$).

The blood picture, urinalyses and liver function tests showed no abnormalities for either group throughout and at cessation of treatment. There was no hypotension or abnormal rise in blood pressure as a result of medication, and little or no influence on body weight. No side effects developed in either group.

Iprindole appears effective and safe as an antidepressant for all types of patient, and particularly for the senile.

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THE VIEW BOX

Leon Love, M.D.
Director, Diagnostic Radiology
Cook County Hospital

This 63-year-old white male had intermittent difficulty with regurgitation and chest pain, particularly noted when he had chewed his food hastily. He first had these complaints five years ago. Following esophagoscopy his complaints have increased and he now states that he has to take anti-acids to relieve the burning in his chest. There is no history of weight loss.

Physical examination is unremarkable.



Figure 1

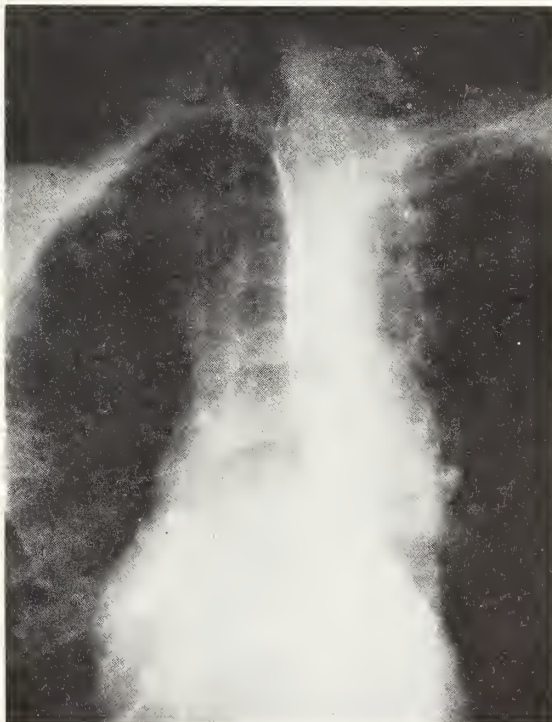


Figure 2

What is your diagnosis?

- 1) Carcinoma of esophagus
- 2) Chemical stricture
- 3) Esophagus lined with gastric mucosa
- 4) Carcinoma of lung invading esophagus.

(answer on next page)

THE VIEW BOX

DIAGNOSIS AND DISCUSSION



Figure 3

Diagnosis: Esophagus lined with gastric mucosa (Allison and Johnston's anomaly)

On esophagoscopy no evidence of malignancy was found. Representative biopsies were taken at 23 cm., 29 cm. and 37 cm. The narrowed esophageal-gastric junction was at 29 cm. At this point, only columnar epithelium could be found. This is not hiatus hernia.

The following conclusions can be made:

1. The uncomplicated condition is largely undiagnosable by X-ray.
2. The lower limit of the stricture of

peptic esophagitis marks the mucosal transition.

3. If the mucosal transition is above 30 cm., then a portion of the esophagus is lined with gastric mucosa.
4. If the stricture of peptic esophagitis is shown to be above the constriction of the cardiac sphincter, then the esophagus is lined with gastric mucosa.
5. If a definite ulcer crater is identified, then the niche is in the gastric mucosa.

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THERE IS INCREASING INTEREST in simplified blood glucose determination because of the renewed emphasis on screening programs for diabetes mellitus as well as greater awareness of the pre-diabetic state. Probably the two most commonly used methods for measuring blood glucose are the Folin Wu (reducing substances) and the Somogyi Nelson (true blood glucose). Both of these require various chemicals, 8 to 20 minutes of boiling, spectrophotometric readings and a total time of about 45 to 60 minutes including preparation of the filtrate. In large institutions where such determinations are made daily in great numbers, the costly Auto-Analyzer apparatus is employed. The use of paper impregnated with glucose oxidase has been reported by Lipscomb et al,⁴ and others⁶ but is still experimental. Several variations of the enzymatic method for blood glucose using glucose oxidase and peroxidase have been described such as the micromethod of Saifer and Gerstenfeld.⁵

The purpose of this study is to present a rapid, simple and reliable method for blood glucose determination which requires only 3 chemicals including the prepared color reagent, 5 minutes of boiling, a total test time of approximately 15 minutes and permits readings with or without the spectrophotometer.

Our method lends itself readily to use in the doctor's laboratory because of its simplicity and low cost of equipment and chemicals. The test is based on the fluoran reaction as described by Dominikiewicz.¹

Preparation of the Reagent

The fluoran reagent 2, 7, dioxy, 3, 6, dinitro fluoran was prepared by one of us according to the method of Eckstand.³

To a mixture of 124 Gm. of hydroquinone and 83.6 Gm. of phthalic anhydride (molar ratio 2:1) in a liter flask placed in a hood add cautiously, in small aliquots with constant mixing, 120 ml. (276 Gm.) of stannic chloride. After the initial reaction has subsided, the flask is placed in an oil bath and maintained at 120° for 16 hours. A black, tarry, highly viscous reaction mix-

A SHORT METHOD FOR BLOOD GLUCOSE DETERMINATION

Sophie J. Presley, M.D., Clarence A. Johnson, Ph.D., Jerome T. Paul, M.D., and Eugene J. Ranke, M.D./chicago

ture results. Before cooling, about 400 ml. of water are added and the heating process continued at a somewhat lower temperature for 4 hours with occasional mixing. The aqueous suspension is allowed to cool and the residue is washed successively by centrifugation to remove water soluble matter which is discarded. 2, 7 Dihydroxyfluoran (hydroquinonephthalein) may be extracted from the tarry residue by refluxing with 60% ethyl alcohol. On filtration and cooling the compound crystallizes in white needles (M.P. 232°) from the alcoholic solution. Several recrystallizations in the presence of charcoal are necessary to remove extraneous colored matter. The conversion of 2, 7 dihydroxyfluoran to 2, 7 dihydroxy, 3, 6, dinitro fluoran is accomplished as follows:² 10 Gm. of the former are suspended in 100 ml. of hot glacial acetic acid and 10 ml. of fuming nitric acid are slowly added while stirring. The nitrated compound separates out as an olive-orange precipitate when the cooled solution is poured into 200 ml. of water. It is

Departments of Medicine and Biological Chemistry, the University of Illinois College of Medicine, Chicago.

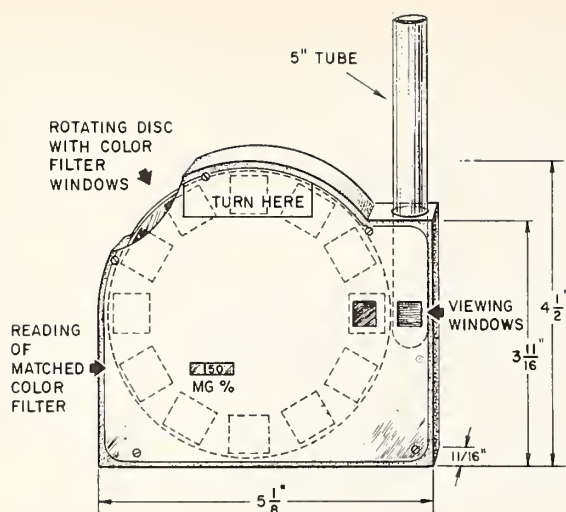


Figure 1: Color filter instrument with rotating color scale matching blood glucose concentrations in the range of 50 to 350 mg. %

collected on a Buchner funnel, washed and dried.

The powdered crystals are olive in color, have a rhomboid shape and M.P. of 227°. The fluoran reagent is relatively stable at room temperature in the dry form. To prepare the reagent solution, 0.5 Gm. of the powdered crystals and 0.25 Gm. of sodium bicarbonate are dissolved in 100 ml. of distilled water. The solution is orange in color and remains stable for at least two weeks if protected from light and heat.

Glucose Determination on Whole Blood

One ml. of oxalated blood is added to 9 ml. of 10% trichloroacetic acid (TCA), stirred briefly and filtered. The test is done on 4 ml. of the clear filtrate. To this is added 1.2 ml. of 2 N NaOH followed immediately by 0.1 ml. of the fluoran reagent and the solution mixed. If the spectrophotometer is to be used, a blank using 0.4 ml. of distilled water, 3.6 ml. of 10% trichloroacetic acid (TCA), 1.2 ml. of the alkali and 0.1 ml. of the reagent is prepared at the same time. The tubes are then immersed in a boiling water bath for exactly five minutes. The golden yellow solution slowly becomes almost black, then suddenly changes to a golden pink, pink red or cherry red color depending on the amount of glucose present. The tubes are

cooled by immersion in cold water for two to three minutes. The solution is then transferred to appropriate tubes and read directly against a standard color filter scale, Figure 1, or on the Coleman spectrophotometer at 520 mμ against the blank. With the latter procedure results are read in mg. % from a conversion table based on a standard curve of known glucose concentrations. Readings average 18 mg. % higher than the "true glucose" values for the same blood specimens obtained with the Auto-Analyzer method (Table 1). Values above 400 mg. % are difficult to read accurately on the spectrophotometer.

Standard Color Filter Scale

The instrument designed by us and shown in Figure 1 consists of 12 transparent color filter windows mounted in a metal disc within a metal housing approximately five inches in length. Each window is made up of several gelatin color filters cemented together and prepared to match exactly the colors of the standard test solutions containing 50 to 350 mg. % of glucose in gradations of 25 mg. %. The test tube with the solution to be read is inserted in a special groove and the color windows rotated slowly allowing only one to be viewed at a time alongside the tube until matched. Results agree within 25 mg. % of known values on the same blood specimens analyzed by both the fluoran spectrophotometer method and the Auto-Analyzer method.

Reproducibility of Results

Twenty-two blood samples were analyzed in duplicate by the fluoran method using the spectrophotometer. Individual values agreed within -12 to +11 mg. % with an average difference of 0.5 mg. % (Table 2).

Discussion

The fluoran method for blood glucose determination presented in this report appears to be a reliable and accurate procedure easily adaptable to rapid analyses. The reduction of 2, 7 dioxy, 3, 6 dinitro fluoran to the sodium salt of the diamino fluoran as described by Dominikiewicz¹ is

not specific for glucose since mannose, galactose, fructose, 1-arabinose, xylose, lactose and maltose will also give the reaction. It does not occur with sucrose, raffinose, starch, mannite, glycerol, formaldehyde, glyceraldehyde and inulin. According to this author the reaction "occurs only in the presence of a CHOH-CH(OH)-O- group or a CHOH-CHO group with an open aldehyde chain."

In the course of our study an attempt was made to apply this method to true blood glucose values by eliminating non-glucose reducing substances from the blood when preparing the protein-free filtrate. This was done by using the 1:10 dilution with

more concentrated solutions of Barium hydroxide and Zinc sulfate. It proved impractical however, because of variable results. Various methods of protein precipitation were tried by us in order to find the shortest one that would give a 1:10 dilution. Sodium tungstate (10%) gave this dilution but required approximately 20 minutes to obtain the filtrate. A 50% concentration of Sulfosalicylic acid gave variable results. A sulfosalicylic acid reagent comparable to the Dextrotest reagent (Ames Co.) gave higher results. This led to substituting 10% TCA as the precipitating agent as described.

In doing the fluoran test it is important to note that when the blood filtrate is made alkaline with NaOH it must be treated immediately with the fluoran reagent. The exact addition of 0.1 ml. is equally important to: (1) insure that all the glucose present is utilized in the reduction process and (2) avoid possible altering of the intensity of the end color by an excess of the

TABLE 1

Comparison of Blood Glucose Values with Fluoran and Auto-Analyzer Methods on the Same Blood Specimens (Total 30).

Fluoran Method mg. %	Auto-Analyzer Method mg. %	Difference (Plus)
115	109	6
105	92	13
97	88	9
105	88	17
128	113	15
286	276	10
167	150	17
106	96	10
265	247	18
141	128	13
145	129	16
248	227	21
111	93	18
108	96	12
228	210	18
119	94	25
234	205	29
250	227	23
392	366	26
110	95	15
161	133	28
203	174	29
121	95	26
122	97	25
235	220	15
121	93	28
96	83	13
129	102	27
318	308	10
95	91	4
Average 168.7	149.8	17.9
	S.D.	7.7

TABLE 2

Reproducibility of Results Using Duplicate Blood Filtrates. 22 Blood Specimens.

Individual Values in Mg. %	Average	Difference in Mg. %
263 and 266	264.5	3
134 141	137.5	7
143 147	145	4
252 245	248.5	—7
110 111	110.5	1
114 102	108	—12
229 228	228.5	—1
120 118	119	—2
237 231	234	—6
248 253	250.5	5
389 395	392	6
112 105	108.5	—7
162 160	161	—2
200 206	203	6
120 122	121	2
122 122	122	0
236 239	237.5	3
123 118	120.5	—5
96 96.5	96.25	0.5
130 128	129	—2
315 320	317.5	5
89 100	94.5	11
	Average	0.5
	S.D.	5.5

color reagent. Readings with or without the spectrophotometer should be made within 15 minutes. If the cooled solution is allowed to stand at room temperature for 30 minutes or longer, there is a very gradual fading of the color. The fluoran method gives readings averaging 18 mg.% above the Auto-Analyzer true blood glucose method.

The simplicity of the technique and the rapidity with which results can be obtained are the advantages which make this test useful and adaptable to the small private laboratory.

We are indebted to Mr. F. Sharp, principal scientific photographer, at the University of Illinois for technical suggestions and assistance.

Summary

1. The fluoran method for blood glucose determination is presented as a rapid, simple and reliable method readily adaptable to the office laboratory.

2. It represents the reduction of 2, 7

dioxy 3, 6 dinitro fluoran to the sodium salt of the diamino fluoran having a cherry red color the intensity of which is proportional to the glucose oxidized.

3. Glucose values are obtained by comparing the color developed by the reagent with the color filter scale of the instrument in the range of 50 to 350 mg.% in 25 mg.% gradations. The method is also adaptable to the Coleman spectrophotometer.

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SPECIAL LEGISLATIVE REPORT

RE: DARLING V. CHARLESTON COMMUNITY MEMORIAL HOSPITAL CASE NO. 38790 IN THE SUPREME COURT OF ILLINOIS

On September 9, 1965, the Supreme Court of Illinois handed down a decision of the Appellate Court and sustained a judgment against the hospital in the amount of \$110,000.

This is the case of the highschool student who suffered a broken leg while playing football, which leg later had to be amputated, necessitated by restriction of blood circulation caused by the plaster cast on the leg. The physician in the case was also sued but settled out of court and is not involved in this case. The factual situation clearly demonstrated gross negligence.

While this case has several serious ramifications, the following language from the opinion we believe to be of considerable

importance to all physicians, which language is as follows:

'At that point it became the nurse's duty to inform the attending physician, and if he failed to act, to advise the hospital authorities so that appropriate action might be taken.'

As a result of this unfortunate language hospital administrators may feel that they have to scrutinize serious cases to a greater degree and could even result in physicians being second-guessed by some of the nurses.

The hospital filed a petition for rehearing but this was denied by the Supreme Court on November 18, which means that this decision now becomes final.

RUPTURE OF THE PREGNANT UTERUS WITH DELAYED TREATMENT

*Allan G. Bennett, M.D. and
W. Robert Malony, M.D./Carbondale*

RUPTURE OF THE PREGNANT UTERUS is an emergency requiring prompt surgical intervention. However, Jaffe¹ recently reported a patient whose diagnosis and laparotomy were delayed for a period of two months after the occurrence of uterine rupture. The purpose of this report is to present another patient whose diagnosis and treatment of spontaneous uterine rupture were delayed.

Case Report

The patient is a 34 year old white female, gravida 8, para 6, aborta 1, whose expected date of confinement was January 4, 1965. Her past medical and obstetric history was unremarkable.

After a normal pregnancy she was admitted to another hospital on January 6, 1965 in active labor with the fetal vertex presenting. The membranes ruptured spontaneously on the morning of admission, and labor progressed satisfactorily until the cervix was dilated to 8 cm., at which point arrest occurred and contractions ceased. There was very little external bleeding. The patient was given oxytocin intramuscularly in divided doses, but further progress failed to occur.

On January 7, the following day, the patient was again examined. The fetus no longer appeared to be in a vertex presentation, and an X-ray was taken. This showed the fetus to be in a transverse lie.

That night the patient developed severe right upper quadrant abdominal pain and was thought to be having a gallbladder attack. She was given intravenous fluids and tetracycline. She reported that fetal movements which had been present until the previous day had disappeared. Fetal heart tones were at no time audible.

On January 8 she felt better. She was given a soft diet, and penicillin therapy was started. Hematocrit at that time was 38%.

The same regimen was carried out on January 9. On that day she passed approximately 200 cc. of blood per vaginam.

In the early hours of January 10 she began to bleed more heavily and vomited coffee ground material. She was then transferred to Doctors Hospital, Carbondale.

Physical examination on admission showed a patient whose height was approximately 5 ft., 2 in., and weight approximately 225 lbs. These measurements were not taken because she appeared to be seriously ill. Temperature was 99.8°, pulse 140 and thready, respirations 24, and blood pressure 104/88. The abdomen was grossly enlarged, and no fetal heart tones could be heard. There was a foul serosanguinous discharge from the vagina. The cervix was high, and no presenting part could be palpated.

An X-ray of the abdomen showed a large

fetus in a transverse lie. White blood count was 9700 with a shift to the left. Hemoglobin was 10.9 gm. %, hematocrit 34%. A catheterized urine was normal. Serum electrolyte levels were unremarkable.

Intravenous fluids, oxytetracycline, penicillin, and one unit of cross matched blood were administered through a venous cut-down, and surgery was performed under spinal anesthesia four hours after admission. The patient received a second unit of blood during the operation.

The abdominal cavity was entered, and an 11 lb. macerated male fetus was found lying free in the upper abdominal cavity. Attached to it, and also lying free within the abdomen, was the macerated placenta. An extremely foul odor was released from the abdominal cavity. A culture of the peritoneal fluid was taken but later showed no growth. The uterus was found to have partially contracted and extended to just below the level of the umbilicus. The right lower posterior uterine wall between the insertions of the right broad and uterosacral ligaments was ruptured. This area was filled with pus. After the fetus and placenta had been removed, a supracervical hysterectomy and bilateral salpingo-oophorectomy were performed. Penrose drains were left through the vault of the vagina. The abdomen was closed with interrupted through-and-through stainless steel wires. Hematocrit that evening was 36%.

Convalescence was stormy. For the first several days she received intramuscular streptomycin and large doses of intravenous penicillin and chloramphenicol. She developed a urinary infection due to *Aerobacter aerogenes*, a toxic dermatitis, and decubitus ulcers at various times in her postoperative course. Temperature returned to normal on the twenty-first postoperative day. She was discharged from the hospital on the twenty-second postoperative day and appeared to be in good health at examinations one week and one month later.

Discussion

The incidence of rupture of the pregnant uterus varies considerably, depending on

the area from which the report is obtained. Rendle-Short² reported an incidence of 1:93 hospitalized cases in Uganda, East Africa. Most studies from the United States report an incidence of from 1:1000 to 1:2000.³

Uterine rupture is classified under three main headings: spontaneous rupture of the uterus upon which caesarean section or other surgery has been previously performed, spontaneous rupture of the intact uterus, and traumatic rupture of the intact uterus. The latter is usually the result of obstetric manipulation. In the United States in recent years, the majority of ruptures have occurred in previously scarred uteri. Ferguson and Reid⁴ found that 71% of their cases had previously undergone caesarean section.

Spontaneous rupture of the intact uterus is less common and carries a higher maternal and fetal mortality. It occurs most commonly in the elderly, multiparous patient. Josey⁵ reported a maternal mortality rate from many collected series of 36% from rupture of the intact uterus as opposed to 6% from rupture following caesarean section. With prompt diagnosis and effective treatment, maternal and fetal mortality can be greatly reduced. Waters and Hall⁶ were recently able to report a series of 50 uterine ruptures from all causes without a maternal mortality.

This unusual case of uterine rupture occurring four days before diagnosis and treatment has been presented to show that survival can still occur. Early diagnosis and prompt laparotomy, blood replacement, and measures to combat infection remain the cornerstones of effective therapy.

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EDITORIALS

CURRENT STATUS OF THE RUBELLA PROBLEM

The *Illinois Medical Journal* is fortunate in having an excellent review of the current status of the rubella problem. The paper entitled "Acute and Chronic German Measles" is authored by Drs. John L. Sever and Lon R. White of the National Institute of Health. Dr. Sever has contributed several excellent papers on rubella and is widely recognized as a national authority on the subject. He has demonstrated that 15% of pregnant women between the age group sixteen to twenty-five do not have antibodies to rubella.¹

He states that most susceptible women in the childbearing age develop the disease when exposed, but only one-third to one-half have skin lesions. He stresses the importance of finding the virus in infected infants for many months after birth. Petechia, thrombocytopenia, hepatosplenomegaly and radiolucencies of the long bones are present in some of these cases.

Dr. Sever has also reported the development of a 24-hour fixation test for determining antibodies to rubella, making it possible for the mass screening of the serum of 5,000 women daily.² This new test will become widely employed as soon as public health agencies develop and implement mass screening programs.

It is hoped that a rubella vaccine will be developed soon. This could eliminate the future danger of having 20,000 or more infants born each year suffering from the effects of intra-uterine rubella.

Harvey Kravitz, M.D.

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ON THE EVE OF MEDICARE

James W. Haviland visited the New York Academy's 1965 Health Conference and reported his impressions in the *Bulletin of the American College of Physicians*. He admitted that "not for a long time have I felt so completely out of step with current events and plans." This is understandable because he was the only practicing physician participant. Following are a few of the items that were stressed by individual speakers:

Health is a right and the way to solve our problems in the health field is to get more Federal money. Certain speakers "felt that the people of this country will decide to what extent changes in health care practices are made, probably on the basis of pressures stemming principally from needs, types of information presented to

them, actual numbers of people involved and political pressures."

It was agreed that controls will have to be exercised and one speaker mentioned professional, fiscal and legal. Quality also must be maintained and this will become one of the very real problems of the future. Dean Rappleye emphasized that while others might administer the programs, only physicians can actually provide medical care. Dr. David Rutstein of Harvard stressed the point that physicians' services will be the limiting factor in the years ahead, as the yet undetermined health care program gets under way. In his opinion we need to produce more physicians and to increase the efficiency of those we have.

Another group of speakers concluded that "Hospitals are being groomed to become

the center for providing and distributing all types of medical and health care to the community. This will enable more emphasis to be placed on 'comprehensive care.' Consequently, solo practice will be replaced almost entirely by group practice, especially by hospital-centered groups. 'Ambulatory care' will be used to a far greater extent than at present." (In this connection it seemed to Dr. Haviland that almost all of the speakers were thinking and planning in terms of the very densely populated areas of the county, and of hospital outpatient department organizational structuring. There was no evidence that the speakers were aware of the fact that the preponderance of health care is provided presently on an ambulatory basis by practicing physicians.)

Dr. Haviland mentioned several of his thoughts and impressions of the meeting. It was his opinion that "The social welfare

planners seem to have no goal short of complete health care for all citizens at government expense. They have little apparent practical concepts of methodology, except to pour more money in to solve any medical problem that may arise." He also was of the opinion that the AMA could function effectively in the immediate future to discredit these ideas, yet no one mentioned any organization better able to represent the medical profession at the Federal level.

Dr. Haviland also concluded from attending this meeting that we need "objective, thoughtful, forward-looking leadership more than anything else at this moment. This would apply not only to the medical profession, but also to the country as well . . . Quality, ethical care must survive . . . Physicians must be kept informed concerning the social as well as the legislative changes that are in progress."

T. R. Van Dellen, M.D.

PROJECTING THE TRIUMPHS OF TODAY

Two physicians from the University of Amsterdam removed the heart from a dead man, revived it and kept it alive and beating for more than six hours. Drs. Dirk Durrer and Frits L. Meijler got permission from a relative and spent an hour and a half removing the organ.

The technique for keeping the heart alive was told at the annual meeting of the American Heart Association. The myocardium was scarred and damaged because of recent and former infarctions but capable of contracting at reduced efficiency. The Dutch physicians conducted the experiment to learn more about the physiology of the isolated heart.

We are rapidly reaching the time when it may be necessary to change our definition of death. Organ transplantation and substitution is now a well-established specialty and is creating many problems of a moral and legal nature. Medical progress has outstripped the law in some instances; the rights of donors and recipients of live and cadaver organs may need legal clarification.

We can visualize the time when donors will be so scarce that a person cannot afford the luxury of his vital organs sent to the grave. Laws may be passed allowing the use of cadaver hearts, kidneys, lungs, and brain to protect the physician and the recipient. Most of us will not live to see this happen but it is interesting to speculate on how many borrowed organs a person can take before he loses his identity. The moral aspects of these surgical shenanigans is beyond my comprehension.

At the other end of life's span we have scientists working on the synthesis of life. This project is more difficult although we read recently of the successful synthesis of a virus. Meanwhile, we are encouraged to stop the population with contraceptive pills and intrauterine devices to prevent the ovum and sperm from getting together. These little fellows are not chemists or geneticists and cannot tell the difference between a DNA and an RNA molecule, but they sure know how to synthesize.

T. R. Van Dellen, M.D.

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Capsules
oxytetracycline 250 mg., nystatin 250,000 units
For Oral Suspension
oxytetracycline 125 mg., nystatin 125,000 units/5 cc.

Contraindicated: In individuals hypersensitive to oxytetracycline or nystatin.

Warning: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth.

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Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply: Terrastatin Capsules: oxytetracycline, 250 mg. and nystatin, 250,000 units. Terrastatin for Oral Suspension: oxytetracycline, 125 mg. and nystatin, 125,000 units per 5 cc. (when reconstituted).

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BOOK REVIEWS

HOSPITAL HAPPINESS. Vic Fredericks & Herb Suf-rin, 207 pages. \$2.95. Frederick Fell, Inc., New York, New York.

Many hospital patients enjoy humor and other light reading. The authors present a preview of a fourteen day routine from the pre-dawn tray clatter to the rude post-midnight awakening by a fiendish night nurse with a sleeping pill. The reviewer allowed two patients to read it and both agreed that the book was great.

T. R. Van Dellen, M.D.

THORACIC SURGERY, VOLUME II. Edited by Frank B. Berry, M.D. Government Printing Office, Washington, D.C., 1965. 615 pages, 222 illustrations, \$7.25.

This is the second of two volumes comprising the history of thoracic surgery in the U. S. Army Medical Department in World War II. Edited by Dr. Frank B. Berry, and written by surgeons, now nationally and internationally known, who actually participated in the dramatic development of thoracic surgery during the war, this book tells the story of an outstanding medical achievement.

The second volume on thoracic surgery deals with special types of thoracic and cardiac wounds, thoracoabdominal wounds, the complications of these wounds and surgical diseases of the chest as they were observed and treated in the Zone of the Interior general hospitals. The present-day further advancements in thoracic surgery had their inception in the lessons and techniques learned and described therein, making this book a comprehensive and particularly valuable reference source for all thoracic surgeons.

The final chapter is a follow-up study by Dr. Lyman A. Brewer III, made in 1960-61, of the 167 casualties who sustained chest wounds in Italy during 1943-45. The survival of these men, the x-ray evidence of their healthy thoracic status and the normal lives practically all of them were living bear witness to the surgical skill and wisdom of the treatment they had received during the war period.

FROM AUSCULTATION TO PHONOCARDIOGRAPHY by Aldo A. Luisada with the collaboration of D. M. MacCanon, L. M. Rosa, P. M. Shah, R. Zalter. C. V. Mosby Co., St. Louis, Missouri. 1965. 351 pages, 196 illustrations Price \$17.75

Dr. Luisada and his group have been active in the field of the graphic recording of various cardiovascular events for many years, and they have been prolific in their writing. The present volume assembles much of the material regarding phonocardiography in particular collected by the

(Continued)

members of the laboratory. There are four sections: one on the physiology of heart sounds and murmurs, one on auscultation, one on the technical aspects of phonocardiography, and one on the clinical aspects of phonocardiography. While the authors refer extensively to their own work, there is frequent allusion to the contributions of others with brief but interesting historical notations.

The first section of some 48 pages is relatively concise. There are summarized the various conflicting views as to the mechanism of the four heart sounds, with the opinion of the writers in each instance, opinions which are at variance with many of the traditional concepts. The second section on auscultation is more brief, occupying only 21 pages, and it is clear that the authors are anxious to hurry on to the final two parts on phonocardiography which comprise the bulk of the volume. It is perhaps understandable that auscultation should be given such short shrift but it does lessen the value of the book for students and physicians generally who, working in the office, clinic, or hospital room or ward must use palpation and the stethoscope as the routine means of identifying and interpreting heart sounds and murmurs. One may question the correctness of the conclusion that a murmur is the result of "abnormal" flow (on the previous page, "innocent murmurs" are mentioned). As indicated in the text, there may be many instances of the production of audible and recorded vibrations associated with varied patterns of flow; such situations are not necessarily all "abnormal."

The final two sections on phonocardiography which take up the bulk of the volume give much valuable summary information regarding heart sounds and their recording, systolic and diastolic murmurs, and the findings in states such as myocarditis, pericarditis, and types of arrhythmias. The illustrations are generally helpful, and the text is clear. Of especial importance is the description of the range of situations in which a finding such as an opening snap, or a loud fourth sound may be found. The discussion points—more than the text emphasizes—to the need to correlate both auscultatory and phonocardiographic information with other types of clinical and laboratory data to permit the best possible interpretation.

The book does not supplant other volumes which are available and which also cover the areas of auscultation and phonocardiography. Particularly however for internists and cardiologists, it is a helpful addition to one's library as representative of the point of view of an active group as well as offering some review of the contributions of others.

Oglesby Paul, M.D.

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benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.



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Precautions and adverse reactions: The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously after a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually on higher than recommended dosage. Hydroxyzine HCl may potentiate barbiturates, narcotics such as meperidine, and other CNS depressants. In consecutive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution**
Precautions and contraindications: This dosage form is intended only for I.M. or I.V. administration and should not under any circumstances be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. Due to infrequent phlebitis and, rarely, reversible hemolysis with hemoglobinuria, resulting from too rapid intravenous administration of the solution, administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; on rare instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intra-arterial injection or intra-arterial extravasation, both of which should be avoided.

GRANTS

The University of Chicago has received a \$30,000 gift to support a fellowship in the Department of Medicine of its School of Medicine.

The gift was made by Alvin I. Handmacher, President and Chairman of the Board of Handmacher Vogel, Inc., 533 Seventh Avenue, New York City.

The Alvin Handmacher Fellowship in Gastroenterology will be awarded annually for the next four years to an outstanding candidate in the field of gastroenterology who has completed his or her medical residency and post-doctoral training and who is preparing for a career in academic medicine. The annual stipend will be \$7,500.

Alvin I. Handmacher is a native of Chicago and attended The University of Chicago. His father, Max Handmacher, was a pioneer clothing manufacturer in the city.

In 1952, Alvin Handmacher was elected to the Board of Directors of the United Cerebral Palsy Foundation.

Research grants from the National Institutes of Health, totaling more than \$212,000, have been received by the Hektoen Institute for Medical Research of Cook County Hospital.

The funds are earmarked for Institute investigators probing various aspects of a number of human disorders, including those that affect the heart, liver and kidneys.

Hektoen scientists receiving NIH grants are:

Dr. George Sutton, assistant director, department of adult cardiology, \$45,779 for the continued study of heart muscle disease in the alcoholic.

Dr. David H. Elwyn, chief biochemist, department of surgical research, \$39,600 for the continued study of rate reaction of amino acids in mammals.

Dr. Philip Freedman, principal investigator of renal disease, \$28,788 for the continued study to determine a more effective treatment of nephritis.

Alvin Dubin, director, and Dr. Charles F. Lange, chief biochemist and head of the

physical chemical laboratory, department of biochemistry, \$27,608 for the further study of the relationship of urinary proteins to renal disease.

Dr. William C. Shoemaker, director, department of surgical research, \$27,397 for the study of disturbed circulation and metabolism in patients suffering trauma, hemorrhage and other forms of stress.

Dr. Rolf M. Gunnar, associate director, department of adult cardiology, \$16,495 for a study into shock produced by low blood pressure, weak heart muscle, loss of blood, excessive body fluids or resistance to circulation.

Dr. Paul B. Szanto, director, department of pathology, \$13,314, for continued research into tissue analysis of organs such as the liver, in the chronic alcoholic.

Dr. Maurice Levi, principal investigator, Willis J. Potts Research and Training Center for Congenital Heart Disease, \$6,984 for continued research to determine the nature and cause of heart and great vessel malformations.

Dr. Milton Weinberg, director, department of cardiothoracic surgery, \$6,300 for the continued study of heart chamber and related defects by a variety of exploratory methods.

George E. Block, associate professor of surgery, University of Chicago, has received the 1965 McClintock Award.

The \$500 award is given annually to an "outstanding teacher" in the University's School of Medicine, as selected by the school's senior class.

The award was first made in 1960 by Dr. James A. McClintock, a graduate of the University's School of Medicine, who sponsors the award in honor of his father, James A. McClintock, a former Purdue University faculty member. The elder McClintock died in 1961.

Dr. Block joined the University faculty in 1960 as an assistant professor of surgery. He was named associate in 1964. In 1955, he was a Post Doctoral Fellow at the University's Ben May Laboratory for Cancer Research.

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Persantin, brand of dipyridamole, is available as tablets of 25 mg. Two tablets (50 mg.) 3 times daily, at least 1 hour before meals, is the recommended dosage. Clinical response may not be evident before several weeks of continuous therapy.

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No specific contraindications are known. Since large doses can produce peripheral vasodilation, the drug should be used cautiously in patients with hypotension as, for example, in acute myocardial infarction when the blood pressure may be labile. Headache, dizziness, nausea, flushing, weakness or syncope, and mild gastrointestinal distress have been reported.

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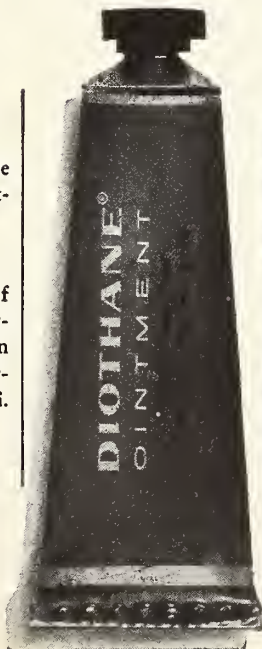
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Dr. SIMS in ACTION

ADMINISTRATIVE AND COMMITTEE ACTIVITIES
OF THE ILLINOIS STATE MEDICAL SOCIETY

December, 1965

Ad Hoc Committee on IUCD's

The Illinois State Medical Society's Ad Hoc Committee on Intra-Uterine Contraceptive Devices met on October 22 in the Society's headquarters. The Committee members are Drs. Edwin DeCosta, Newton DuPuy, H. Close Hesseltine, Chairman, and Fred A. Tworoger, Consultant to the Committee.

Dr. Tworoger discussed the problems relating to the use of the device for public aid patients. The IUCD has been in use for several years and is gaining in physician acceptance.

In a review of source material, it was observed that the failure rate due to pregnancy varies from one to five per cent. Some additional five per cent may be expelled and another 10 to fifteen per cent may cause enough bleeding or cramps to lead to removal. In most studies, 80 to 85 per cent of the individuals have continued to use the device after its insertion. The use of the IUCD's eliminates the factors of intelligence and motivation. The Ad Hoc Committee believes that the Intra-Uterine Devices are logical in their purpose and that current evidence supports the extension of their employment.

The Committee recommended that: (1) those institutions and facilities now using the IUCD be authorized to continue their use for public aid recipients; and (2) the Medical Director of the Illinois Department of Public Aid be empowered to authorize individual physicians to use the devices on a study and research basis.

Follow-up reports on utilization experiences should be submitted from these sources to the Medical Advisory Committee to the Illinois Department of Public Aid. This will allow the devices to be reappraised and present evidence for new interpretations and recommendations.

The Committee recommended two devices: the Lippes Loop and the Birnberg Bow. The plastic string should be cut flush with the external os in the instance of the Lippes Loop.

It was further recommended that facilities and institutions already using other IUCD's continue their use in accord with medical judgment during this study period.

These recommendations were accepted by the Board of Trustees and submitted to the Illinois Department of Public Aid. A fee of \$5.00 for insertion, including cost of the device will be paid to the physician by IDPA.

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Here, in Illinois, 50 nations of the world are represented by consulates, tourist bureaus, and information centers.

They are here because of the major role played by Illinois in the economy of this nation and in world trade.

For example, Illinois leads the nation in exports with an annual total of more than \$2 billion. And these exports come from every part of the state: fabricated metal products from Rockford; farm machinery from Moline; processed food products and earth moving equipment from Peoria; petroleum and chemical products from Alton; soybeans from Decatur; pharmaceuticals, appliances, electronic equipment from the Chicago area.

The nation—and world—look to Illinois for leadership in selling and

marketing agricultural goods. In Chicago, the world's largest grain exchange handles trade for 90% of the world's grain futures. Prices agreed upon here are used around the world to determine the cost of agricultural food and fiber.

Through its transportation hub in Chicago, Illinois has direct links with many foreign lands. Fifteen airlines serving this area offer flights to Europe, Japan, the Middle East, Central and South America, Hawaii, Australia, and the West Indies. Here, too, 49 steamship lines provide overseas service to 137 foreign ports in 65 countries ranging from Abidjan, Ivory Coast; and Adelaide, Australia; to Willemstad, Curacao, and Yokohama, Japan.

One out of every five persons traveling to the U.S. clears through customs in Chicago.

Many of these are foreign students.

They come to Illinois to advance themselves through study at one of our outstanding colleges or universities.

With them they bring their own learning, customs, hopes and dreams. And our own children can have the opportunity of widening their own



world while they work and learn with these people.

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Take pride in the promise of Illinois





AAMA NINTH ANNUAL MEETING

"Understanding Through Knowledge" was the theme of the ninth annual meeting of the American Association of Medical Assistants, when more than 800 members from all over the United States gathered in New York City, October 11-17. They represented 43 states and the District of Columbia. Illinois was represented by thirty-four members from Cook, DeKalb, DuPage, Kane, McHenry and Tazewell counties.

Pre-convention social events included a day at the New York World's Fair, a tour through the Automedic hospital on the Fair grounds and conducted tours of New York City, the United Nations and Rockefeller Center.

Evening activities consisted of hospitality parties and campaign parties given for candidates for office by their state associations. One of the highlights was the party Illinois hosted for Mrs. Elvera Fischer who was running for president-elect. The theme was "Land of Lincoln." Dr. Carl Clarke of Sycamore, wearing tails, a stove pipe hat, and beard, was Abe Lincoln. Mrs. Ilene Herrell of Elmhurst, in a pink satin and lace gown, was Mary Todd Lincoln. Official hostesses, all wearing hoop skirted dresses, were: Sue Karels, Irma Voller, Mary Rowland, Claire Brouillette, Corinne Berg, Jan Ellsworth, Thelma Peplow, Mrs. Clark, Dona Dwy, Melba Sebela, and Evelyn Walters.

Other Illinois members who also served as hostesses were: Magda Brown, Mary Dunham, Ethyl Haas, Tommy Haynes, Ruby Jackson, Stella Krystyniak, Luella Mitchell, Marietta Munnis, Synobia Payne, Irene Shapiro, Ruth Slater, Ethyl Pederson, Lina Trotter, Phyllis Bredthauer, Sandra Bredthauer, Shirley Kleinschmidt, Monetta

Wahlberg, Ruth Christensen, Mary Jane Donnelly, Phyllis Vogt, Dorothy Stoffel and Florence Gouliard.

The convention included a two day session of the House of Delegates, the policy making body of AAMA, and an educational program.

The House of Delegates transacted the election of officers for the year 1965-66. Illinois is extremely proud that Mrs. Elvera Fischer of Chicago was elected president-elect. She was selected by a unanimous ballot and will take office as president next October at the annual meeting in St. Louis. She has served as vice-president, trustee, and speaker of the house. She has also held many positions of leadership with her county and state societies.

Wyeth Laboratories sponsored a symposium on office management. It was composed of four sections: "Using Available Communications Equipment," "How to Work Smarter Not Harder," "Following the Patient's Health Needs Outside the Doctor's Office" and "Working With The Medical Management Consultant."

A luncheon honoring James Appel, M.D., president of the AMA, and the past presidents of AAMA was held after the symposium in the Grand Ballroom of the Roosevelt Hotel. Dr. Appel spoke on medicine and government. He discussed medicare and government financing of research on stroke, cancer, and heart disease.

Following the luncheon another series of talks was presented on: "The Patient—Office VIP," "Medical Quackery," and "Medical Who-Dun-Its."

Saturday workshops were held on certification, leadership, membership, parliamentary procedures, public relations and treasurers.

Meeting Memos



January 12—As part of its lecture series on Stress and Adaptation, Forest Hospital is scheduling a lecture on "The Challenge of Experimental Psychopathology" by Louis J. West, M.D., Professor of Psychiatry, University of Oklahoma Medical Center, Oklahoma City, to be held at the hospital, 555 Wilson Lane, Des Plaines, Illinois.

January 18—"The Image of the Surgeon Throughout the Centuries" will be discussed by Leo Zimmerman, M.D., as part of the lecture series presented by the International College of Surgeons Hall of Fame, 1524 Lake Shore Drive, Chicago, at 8:00 p.m. Dr. Zimmerman is former chairman, Department of Surgery, Chicago Medical School; Professor of Surgery, Chicago Medical School; and Professor of Surgery, Cook County Graduate School of Medicine.

February 9—Forest Hospital, 555 Wilson Lane, Des Plaines, Illinois, is presenting "The Role of the Biologist in Mental Health Activities" as part of its Guest Lecture Series, to be given at 8:00 p.m. The speaker will be Fred Elmadjuan, Ph.D., Chief, Biological Sciences Section, Training and Manpower Resources Branch, National Institute of Mental Health, Bethesda, Maryland.

February 15—"Adventure in Leprosy" by Dr. Olaf Skinsnes is being given as part of its tenth lecture series by the International College of Surgeons at the Hall of Fame, 1524 Lake Shore Drive, Chicago, at 8:00 p.m. Dr. Skinsnes is former professor, department of pathology, University of Hong Kong; research grant from American Leprosy Missions; and professor, department of pathology, University of Chicago.

February 16-17—Changing relationships in the voluntary health movement will be the theme of a national invitational conference sponsored by the American Medical Association Council on Voluntary Health Agencies, to be held at the Continental Plaza Hotel, Chicago.

The conference will consider the influence of present and future voluntary and public forces on health agencies.

Subjects to be considered include: communications and public attitudes, community planning, expenditures, legal patterns, continuing professional education and relationships between government and volunteerism.

Registration will begin at 4:00 p.m. Wednesday, February 16, at the Continental Plaza Hotel.

March 21-April 2—The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois will conduct a postgraduate course in "Laryngology and Bronchoesophagology," under the direction of Paul H. Holinger, M.D. This course will be limited to fifteen physicians and will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics as well as didactic lectures.

Interested registrants are requested to write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Illinois 60680.



Rx Reviews

and New Products

Trivalent Sabin Oral Polio Vaccine

Pfizer Laboratories Division, Chas. Pfizer & Co., Inc., has announced that it was making available Sabin oral polio vaccine in trivalent form. The trivalent vaccine combines in a single dose Types I, II, and III of polio virus vaccine.

The minimum recommended dose for trivalent oral vaccine is two doses six to eight weeks apart. However, Pfizer pointed out, the American Academy of Pediatrics recommends that trivalent vaccines be administered in five doses between the ages of two months and entry into school.

The trivalent vaccine is packaged in 10 single dose vials per package of 0.5 ml. aqueous nutrient fluid. The vaccine is tasteless and may be swallowed directly from the vial or given by dropper to infants. The vials are set individually into a molded plastic tray specifically designed for convenient storage in the freezer compartment. Ten disposable plastic droppers accompany each package in a separate container.

The vaccine must be stored at temperatures below zero degree centigrade before using. Once opened, or if the temperature is allowed to rise above freezing, the vaccine must be used within seven days and stored in a refrigerator during this time period. If not used, it should be discarded.

Saran Wrap Dressing

Johnson's Professional Products Co., a division of Johnson & Johnson, is now distributing a special 4-inch wide, 200-ft. roll of Saran Wrap for use as a covering for wet dressings.

The 4-inch width has been found to be ideally suited to medical use, much easier for bandaging than the commercially avail-



able 12-inch wide roll. The dressing is wrapped on like a bandage and secured with suitable adhesive tapes. In some cases, moistened gauze dressings are placed over the treated lesion before wrapping with Saran film. It is believed that the increased humidity under the plastic wrap is a significant factor, as well as the fact that the plastic covering prevents the medication from being removed from the skin surface.

Antibiotic Effective in Skin Infections,

The new antibiotic lincomycin (Lincocin) was "very effective" against staphylococcal and streptococcal skin infections in a recent Canadian study and also produced encouraging results in patients with cystic acne.

"Clinically, lincomycin was eminently satisfactory in the treatment of pyoderma. Patients noted clinical and subjective improvement often within 24 hours. Lesions of dermatitis infectiosa eczematoides and folliculitis involuted in three to five days, whereas furuncles and carbuncles healed in seven to 13 days and remained healed," according to Dr. Ben Kanee, a Victoria, B.C., specialist.

Cellulitis, lymphangitis and lymphadeni-

Rx Reviews (con'td)

tis showed evidence of response within 24 hours and healed completely in three to seven days, Dr. Kanee reported in the *Canadian Medical Association Journal* (93: 220-222, July 31, 1965).

While many patients experienced disturbances of bowel function in the early part of the study, while on a dosage of two 500 mg. capsules initially and one every six hours thereafter, this situation improved when the dosage of the antibiotic was reduced to one 500 mg. capsule every eight hours, three times daily. Desired therapeutic results can be achieved at this dosage, Dr. Kanee said.

Among the five patients with cystic acne, satisfactory control was quickly obtained in four on one capsule a day.

The fifth acne patient was maintained clinically free on this dosage for nine months, but developed new lesions when the dosage was reduced to one capsule every other day. Nevertheless, "this patient . . . was delighted with the results of his treatment, manifested by clearing of his cystic lesions for the first time in 15 years," the clinician reported.

Among the 14 patients included in this trial, Lincocin, first introduced by the Upjohn Company in the U.S. early this year, proved to be very effective against *Staphylococcus aureus* and *Streptococcus hemolyticus* Type A.

Dr. Kanee termed the antibiotic "an effective alternative" in treatment of Gram-positive coccal infections resistant to or associated with allergy to other antibiotics.

A. H. Robins Introduces Dopram® Injectable

Dopram® Injectable (doxapram hydrochloride), a respiratory stimulant developed in the research laboratories of A. H. Robins Inc., Richmond, Va., is being introduced this month.

Available in 20cc. rubber-stoppered vials containing 20 mg/cc with chlorobutanol, 0.5%, as the preservative, Dopram Inject-

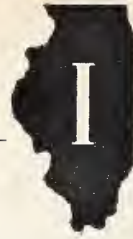


able is unique in its ability to stimulate respiration at dosages considerably below those required to evoke cerebral cortical stimulation. It has a rapid onset of action (20-40 seconds) and wide margin of safety at recommended dosages.

Dopram Injectable (doxapram hydrochloride) is indicated to stimulate respiration in patients with post-anesthetic respiratory depression or apnea other than that due to muscle relaxant drugs; to pharmacologically stimulate deep breathing in the so-called "stir-up" regimen in the postoperative patient; to hasten arousal and return of protective pharyngeal and laryngeal reflexes; and to aid in the differential diagnosis of post-anesthetic respiratory depression.

Dopram Injectable minimizes or prevents the undesirable effects of post-anesthetic respiratory depression or hypoventilation and hastens recovery by promoting the restoration of normal ventilation and producing early arousal following general anesthesia. The earlier return of protective laryngopharyngeal reflexes reduces the likelihood of aspiration.

Complete information concerning the use and administration of Dopram Injectable is contained in the package insert.



Narcotic Addiction Conference Planned

Plans to hold a penetrating conference on Narcotic Addiction to study the increasing narcotic problem in Illinois were announced by the Illinois State Medical Society.

The 1964 Illinois total of 7,407 addicts—which is expected to increase by some 800 each year—is exceeded only by New York.

“The 7,407 addicts reported by the U.S. Bureau of Narcotics represent only those coming to the attention of the law,” said Dr. Joseph S. Skom, chairman of the ISMS Committee on Narcotics. “Undoubtedly, there are thousands more.”

The purpose of the conference, Dr. Skom said, is to bring together various professionals involved in attacking the problem—sociologists, physicians, judges, lawyers, religious leaders, economists, psychiatrists, and law enforcement officials.

“We would hope to create through the conference specialized task forces to work in problem areas most significant in Illinois,” the doctor added.

The conference will be sponsored by ISMS with cooperating organizations including the American Medical Association; Chicago Medical Society; Illinois Department of Mental Health; Chicago Department of Mental Health; U.S. Bureau of Narcotics; and the Council on the Understanding and Rehabilitation of Addicts.

“Guide to Job Placement of the Mentally Restored”

A new “Guide to Job Placement of the Mentally Restored” is designed to ease the doubts of prospective employers concerning the advisability of employing former mental patients.

The booklet points out that the former mental patients are no more inclined to be

jobhoppers than anyone else. In fact, three-fifths of the former patients studied by the Veterans Administration had held the same job for five years or more.

Neither does a history of mental illness imply that a worker is likely to be accident-prone. On the contrary, the booklet indicates that mental patients as a group have as good a safety record as workers generally.

Every executive responsible for hiring should have a copy of the Guide. It is available free from The President's Committee on Employment of the Handicapped, Washington, D. C. 20210.

Institute of Medicine Establishes Committee on Environmental Health

In recognition of the important effect of environmental factors on one's health, the Institute of Medicine of Chicago has established a Committee on Environmental Health.

This action was based on a recommendation by an ad hoc committee which included Dr. Joseph R. Christian, Chairman; Drs. Richard B. Capps, Mark H. Lepper, Edward Press and Theodore R. Van Dellen.

The announcement said that “if, as a nation, we are now throwing off more gaseous and solid waste than the atmosphere can readily accommodate, one can only conjecture as to the future when it is estimated that this country's population will increase to 400,000,000 in sixty years.”

In commenting on the role of the Committee on Environmental Health, Paul H. Holinger, M.D., Chairman of the Institute's Board of Governors, stated that “Substantial progress has been made by chemists, engineers and scientists in analyzing contaminants in the air and water, but much

(Continued)

more must be done to establish acceptable standards for communities. Likewise, the challenge of epidemiological study lies ahead, and the potential role of medicine in identifying the environmental causes of many illnesses and diseases will not be fully recognized for a period of time. In the meantime there is much information to be shared with the doctor by specialists in the area of air and water pollution. As the Institute embarks on its second half century, environmental health will be a most significant field for investigation and study."

AMA Schedules Conference On Air Pollution Research

Air pollution and chronic respiratory diseases will be attacked as interrelated problems during the American Medical Association's first "Air Pollution Medical Research Conference," to be held in Los Angeles at the Ambassador Hotel, March 2-4, 1966.

In addition to the AMA, six other medical and health organizations are mobilizing behind what may well be the largest concerted campaign to be conducted by the medical profession against these problems to date.

The program chairman of the conference is William S. Spicer, Jr., M.D., head of the Division for Pulmonary Diseases of the University of Maryland School of Medicine, Baltimore. Dr. Spicer is an authority on respiratory disease and air pollution.

"The Air Pollution Medical Research Conference is intended to provide a platform for current research to assess the role various factors play. The air pollution-health relationship is to be treated as a complex interaction between biologic systems and environmental conditions, rather than as a simple cause-and-effect relationship," Dr. Spicer said.

The conference, based on the theme, "Biological and Physical Measurement and their Interrelationships," will concentrate on five study areas: 1) basic approaches to the study of the effects of inhaled irritants

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NEWS and ANNOUNCEMENTS

(Continued)

on the lungs; 2) the physical-chemical properties of the environment; 3) biologic determinants of lung responses to air pollutants; 4) differentiation of effects of air pollution from other factors affecting morbidity; and 5) implications of air pollution findings.

International medical, health and engineering scientists engaged in research bearing on air pollution from such countries as England, Japan, France and Italy will be among the approximately 40 participants to present papers.

For registration information write: Air Pollution Medical Research Conference, Department of Environmental Health, American Medical Association, 535 North Dearborn Street, Chicago 60610.

SK&F Adopts Salvage Plan

Smith Kline & French Laboratories has arranged with the nation's principal salvage companies for the return of Smith Kline & French products damaged by fire or other mishap or acquired by salvage companies as a result of bankruptcies.

Smith Kline & French is the first pharmaceutical firm to make an arrangement of this kind.

The company said it adopted the policy so that possibly damaged SK&F products will not be distributed and also to help keep SK&F products from unintentionally getting into unauthorized drug distribution channels.

In the future, SK&F products among distressed merchandise, including partially filled bottles, will be set apart by the salvage company and Smith Kline & French notified. After SK&F and the salvage company negotiate payment, the drugs will be sent to SK&F in Philadelphia where they will be destroyed.

Salvage companies which are co-operating with Smith Kline & French account for about 95 per cent of the salvage of drugs in this country.

Forest Hospital's

out-patient services include an EEG clinic under the direction of Dr. Frederic A. Gibbs. Tests are administered to both adults and children Monday through Friday with appointments scheduled at the patient's convenience. Results and interpretations are mailed to the referring physician on the day following the test. Information concerning clinic procedures will be mailed on request.

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EEG Out-Patient Clinic
Dr. Frederic A. Gibbs, Director

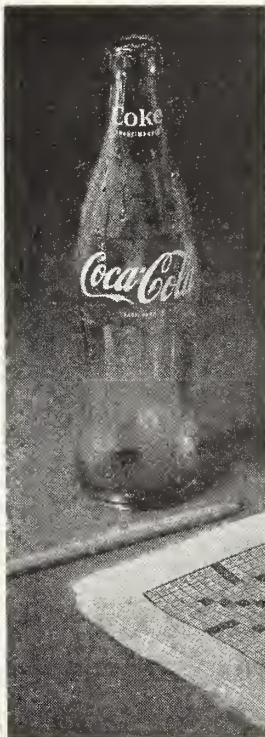
This is one in a series of advertisements describing some of the services offered at the hospital.



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(Continued)

Appointments

Dr. Herbert Sohn, of Deerfield, has been re-elected president of the Alumni Association of the Chicago Medical School for a second two-year term. He is a 1955 graduate.

During his medical school career, Dr. Sohn served as editor-in-chief of the national *Student American Medical Association Journal* (now the *New Physician*).

In 1959 he was awarded the annual traveling fellowship of the North Central Section of the American Urological Association for a postgraduate study in urology at major medical centers of the country.

He is an attending urologist at Louis A. Weiss Memorial Hospital in Chicago.

Other elected to office in the Alumni Association were Dr. Maxwell M. Corbett, of River Forest, class of 1936, first vice-president; Dr. Adam A. Niec, also of River Forest, class of 1942, second vice-president; Dr. Milton Vainder, of Glencoe, class of 1944, secretary, and Dr. Martin L. Gecht, of Glencoe, class of 1944, re-elected treasurer.

Wylie H. Mullen, Jr., M.D., who practices radiology in Joliet, has been elected to a three-year term as a member of the board of directors of the Flying Physicians Association. Dr. Mullen was selected for the post during the association's 11th annual meeting which was recently held at Miami Beach.

Dr. Mullen is a member of the Radiological Society of North America, the American Roentgen Ray Society, the American College of Radiology, and the American Board of Radiology.

The F.P.A. was founded in 1954 to promote safety in general aviation and to explore the various medical disciplines as they relate to aviation. At the present time membership exceeds 1,700 persons and of these more than 100 are practicing physicians in Illinois.

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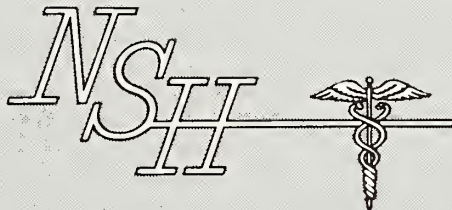
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OBITUARIES

Jay G. Bainhizer*, Pontiac, died July 29, aged 90. He was a graduate of Chicago Homeopathic Medical College in 1898. He was an emeritus member and a member of the Fifty Year Club of ISMS.

Corna L. Bennett*, Danville, died October 29, aged 76. A graduate of Northwestern University School of Medicine in 1910, he was a staff member of Lake View Memorial and St. Elizabeth hospitals as well as physician to federal prisoners. He was an emeritus member of ISMS.

Samuel Brown*, Moline, died July 24, aged 62.

Sidney Brown*, Chicago, died October 29, aged 69. He was a graduate of Loyola University School of Medicine in 1921.

Nicholas I. Fox*, Chicago, died October 15, aged 80. He was a graduate of the University of Illinois College of Medicine in 1914 and he specialized in gastroenterology and internal medicine.

Robert K. Hagan*, Chicago, died November 8, aged 51. A graduate of Loyola University School of Medicine in 1942, he specialized in pediatrics. He was a staff member of Little Company of Mary hospital.

Charles F. Harmon*, Springfield, died November 10, aged 82. He was a graduate of Washington University School of Medicine, St. Louis, in 1910 and he retired in 1954.

Ben L. Hurwitz*, Chicago, died November 16, aged 60. He was a graduate of Rush Medical College in 1930.

Raphael Isaacs*, Chicago, died October 26, aged 74. In 1918 he graduated from the University of Cincinnati College of Medicine and specialized in internal medicine. He was senior attending physician in hematology at Michael Reese hospital, an expert on hemophilia and consulting editor of *Leukemia Abstracts*.

Ellen P. Ketchum, Quincy, died June 4, aged 82. She was a graduate of the University of Illinois College of Medicine in 1904.

Vernon M. Long*, Decatur, died October 22, aged 71. A graduate of St. Louis University School of Medicine in 1925, he specialized in obstetrics.

Ernest M. Montgomery*, Shelbyville, died November 5, aged 85. He was a graduate of Barnes Medical School, St. Louis, in 1907.

Edward J. Pengelly, Chicago, died November 8, aged 84. He was a graduate of Northwestern University Medical School in 1906.

Frederic J. Pollock*, Highland Park, died October 9, aged 56. A graduate of Northwestern University Medical School in 1932, he specialized in otology. He was professor of medicine at the University of Illinois Campus Circle, author of numerous works on medical education, particularly pathology, and served on the research and educational staffs of Michael Reese and Highland Park hospitals for more than 30 years.

Ruth E. Dietz Rock, Broadview, died October 15, aged 43. A graduate of the University of Illinois College of Medicine in 1950, she specialized in psychiatry and was resident psychiatrist at River Edge hospital.

Gustav A. Schupmann*, Warsaw, died August 2, aged 48. He was a graduate of Loyola University School of Medicine in 1943.

William T. Snider*, Danville, died October 15, aged 77. A graduate of the University of Louisville Medical School in 1910, he retired in 1946. Doctor Snider was a member of the Fifty Year Club of ISMS.

Don B. Stewart*, Anna, died September 17, aged 68. He was a graduate of Northwestern University Medical School in 1919 and a surgeon for the Illinois Central Railroad for 46 years.

William G. Turney*, Shelbyville, died November 11, aged 99. A graduate of the Physico-Medical College in 1894, he practiced for over 70 years. He was a member of the Fifty Year Club of ISMS.

Gerrit W. Walvoord*, Chicago, died November 9, aged 89. He was a graduate of the University of Illinois College of Medicine in 1902. He was also a member of the Fifty Year Club of ISMS.

Ralph H. Warden*, Arizona, formerly of River Forest, died June 8, aged 77. He was a graduate of Rush Medical College in 1920 and specialized in radiology.

*Indicates member of Illinois State Medical Society.



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